OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 11 March 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE

9th Meeting 2021, Session 5

CONVENER

*Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Graham Simpson (Central Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
Neil Bibby (West Scotland) (Lab)
*Bill Bowman (North East Scotland) (Con)
*Alex Neil (Airdrie and Shotts) (SNP)
*Gail Ross (Caithness, Sutherland and Ross) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephen Boyle (Auditor General for Scotland)
Fiona Diggle (Audit Scotland)
Caroline Lamb (Scottish Government)
Fiona McQueen (Scottish Government)
Dr Gregor Smith (Scottish Government)
Mark Taylor (Audit Scotland)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

Virtual Meeting

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 11 March 2021

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Jenny Marra): Good morning, and welcome to the Public Audit and Post-legislative Scrutiny Committee's ninth meeting in 2021. I have received apologies from Neil Bibby MSP.

Agenda item 1 is a decision on whether to take business in private. I will assume that members are agreed unless they indicate otherwise. Does any member object to taking items 4, 5, 6 and 7 in private?

No member has objected, so I take that as agreement.

Public Finances (Implications of Covid-19)

The Convener: Item 2 is on tracking the implications of Covid-19 on Scotland's public finances. I welcome our witnesses from Audit Scotland: Stephen Boyle, the Auditor General for Scotland; Mark Taylor, audit director for audit services; and Fiona Diggle, audit manager for performance and best value. I understand that the Auditor General will make a brief opening statement.

Stephen Boyle (Auditor General for Scotland): Good morning, everybody. When I spoke to the committee in August 2020 about the implications of Covid-19 for Scotland's public finances, it was difficult for any of us to foresee the direction of the pandemic. We are, of course, continuing to see the public health and economic impacts. Covid-19 remains the biggest fiscal and policy challenge that the Scottish Government has faced in the past two decades of devolution. There are increasing pressures on public revenues and spending, and the Scottish budget is subject to ever more volatility, uncertainty and complexity. It will remain challenging to match spending to the available funding in the coming years. That will need to be done in a way that minimises the disruption to individuals, public bodies and services and ensures value for money for public funds.

Covid-19 continues to affect Scotland's most vulnerable citizens disproportionately, and it will widen inequalities. The way in which the Scottish Government and public bodies respond to that challenge will be a significant issue in the years to come.

In our briefing paper, "Covid-19: Tracking the implications of Covid-19 on Scotland's public finances", we give an update on the impact of Covid-19 on Scotland's public finances. We present the sources of funding for the budget, and our analysis of the spending announcements to the end of December 2020. We also analyse the emerging risks to the Scottish Government's management of the Scottish budget and to the performance of public services. Finally, we outline how public audit is responding to those matters. It is the second paper in a series, and we will continue to track the impact of the pandemic on the public finances.

The pace and volume of announcements mean that some of the numbers in our paper have been superseded since its publication. We will do our best to capture any changes in our answers. I am joined by Mark Taylor and Fiona Diggle, and we will, between us, look to answer—[*Inaudible*.]

The Convener: Thank you, Auditor General—we lost your audio right at the end, but we caught the vast majority of what you said. I am sure that broadcasting will keep an eye on that.

I ask Colin Beattie to open the questioning.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Auditor General, it is clear that Covid-19 has brought enormous challenges. Contingency planning will be a key element of how we get out of the current situation. Is it clear what the Scottish Government is doing in that regard as we move out of the pandemic—we hope—into a post-Covid world? Is the Government already tackling those challenges adequately?

Stephen Boyle: I agree with you on the importance of contingency planning and, in the context of the paper that we are discussing today, the importance of scenario and financial planning as it relates to the volatility of the circumstances that we are facing. That is absolutely vital. One of the key points that we make in the paper is that effective budget management that allows for all the scenarios, and for volatility, is essential.

In our paper, we refer to the medium-term financial strategy, which is welcome. With regard to allowing for different scenarios, we make the point that there is still scope to go somewhat further with the medium-term financial strategy to allow connections to be made with the outcomes that are achieved as a result of public spending. There is some progress on that, but there is still scope to go further.

Colin Beattie: Which areas of contingency planning do you consider most critical for you to pick up on?

Stephen Boyle: It is essential that we track through from where public spending has been most directly focused during the pandemic. We sought to analyse some of that in our paper, in particular in exhibit 5, in which we analyse where public money has been spent during the pandemic. That will inevitably be an area of focus.

At present, it is difficult to be entirely forward looking, in that the areas of focus for spending activity during the pandemic may not be where Government priorities are as we emerge from it. Priorities change, as do the responses associated with them.

It matters that contingency planning in the round is effective, and that it allows the effective delivery of public services to continue and enables the Government to have the flexibility that it needs in order to respond to events.

As we discussed with the committee previously, it is clear that the volatility—[*Inaudible*.]—that we do not know whether the pandemic is a once-in-a-century event, or whether there will be many more—[*Inaudible*.] We therefore need flexibility and adequate planning—as you suggest—all the more.

Colin Beattie: We know that some areas are definitely under pressure—for example, there are difficulties with addressing backlogs in the national health service, in local government and in the courts. We cannot simply pick up from where we were before—we are significantly behind as a result of the pandemic. Are you satisfied that the Government's contingency planning will address that?

Stephen Boyle: It is probably too early to give you that level of assurance. As you say, there are known issues, as Covid has meant that the delivery of public services has changed fundamentally. You mentioned—and we touch on in our paper—some of the impacts on the justice sector, such as the backlog in the courts. At a recent meeting with the committee—you may be considering this later in today's meeting—we spoke about the backlog in our NHS and what that has meant for waiting times and so forth. The issues are known and understood. The question of what needs to happen will be on the radar of Government and public services at the point when they are able, as part of the on-going delivery of services during the pandemic, to think about what the future looks like. That will involve thinking about whether we return to the normality that we have known, or whether we reimagine how public services can be delivered. All the scenarios need to be captured in the planning that public bodies are doing.

Colin Beattie: You said that you would be doing periodic follow-up reports on the situation. How frequently will those be published?

Stephen Boyle: They will be produced regularly. I hesitate to put a precise number on it, because we are in the throes of finalising our work programme in consultation with colleagues, after we receive feedback from the committee and others in the Parliament. Nevertheless, we anticipate that reports will be published at regular intervals—two to three times—over the year, so that public audit plays its part in supporting public understanding and parliamentary scrutiny of spending. We will continue to do that through a series of reports on what we have termed "following the pandemic pound". We will make judgments about how money has been spent and, as you suggested, report on what that means for the future delivery of public services across our public bodies. There will be regular outputs from Audit Scotland during this year and beyond.

Colin Beattie: Thank you, Auditor General. Our successor committee will be following up on that area after the election, and I am sure that it will be anxious to ensure that those reports are included

in its work schedule, so any indication of frequency would obviously be helpful.

Alex Neil (Airdrie and Shotts) (SNP): Auditor General, I have two questions. First, I want to follow up on the United Kingdom National Audit Office report, "Investigation into government procurement during the COVID-19 pandemic", on the money that has been wasted as a result of the lack of preparedness for the Covid pandemic. The NAO noted that £12 billion was spent on sourcing emergency personal protective equipment, and that, if preparations had been made and PPE had been stored, the cost would have been £2 billion, not £12 billion. On that item alone, therefore, £10 billion of UK taxpayers' money was wasted as a result of incompetence in not preparing for a pandemic. What is the equivalent figure for spending in Scotland, not just on PPE but on associated items?

Stephen Boyle: You may recall that in our NHS overview report, which we have discussed with the committee in the past few weeks, we similarly commented on the circumstances around the Scottish Government's preparedness in terms of pandemic planning. We also drew attention to the scope for more preparedness, in particular in a couple of areas that emerged prominently during the pandemic. One was PPE, and the other was about the extent to which our care homes were prepared for a pandemic.

What we did not do—we spoke in that report about our intention to do this—was examine the detail of what has been spent on the contracts. We signalled that the Scottish Government had used the provisions in emergency regulations to source contracts more quickly and directly than it would otherwise have done through typical tendering arrangements. We are in the process of doing that work, and we will report publicly, through two different routes. One will be a report on the use of PPE, following on from the NHS overview report, and the second will be an audit of NHS National Services Scotland.

We will report on that during 2021, so I do not have a figure for you yet that would enable a comparison to be drawn between the amounts that Scotland spent and what it has subsequently spent, and any value-for-money judgment to be made in that regard. We will follow through on that and report on it publicly during the year.

Alex Neil: Why is it that the UK National Audit Office could give us a figure six weeks ago, but Audit Scotland cannot give us a figure for Scotland yet?

Stephen Boyle: We are in the process of doing that work—

Alex Neil: The NAO must have done that work, so why have you not done it already?

Stephen Boyle: Forgive me, Mr Neil—we are in the process of doing that work, and we will report on it as soon as we are able to. You can rest assured that we want to do that. We are prioritising—

Alex Neil: That does not answer my question. The UK National Audit Office has done the calculations on £12 billion-worth of PPE in that timescale. The timescales for securing PPE and so on were the same north and south of the border. Why has your office not yet produced an equivalent figure for Scotland?

Stephen Boyle: We will be producing a figure, Mr Neil, and we will report—

Alex Neil: That does not answer the question. Why have you not done it?

Stephen Boyle: We are in the midst of doing it, and we will be reporting on it as soon as we are able to. I recognise the timescale on which the NAO has produced its work. We are doing the work, and we will be reporting as soon as we are able to. You can rest assured that it is a very important matter for us. It is a continuation of the work that we have already been doing on PPE through the NHS overview report, and we will be reporting in two further ways: through a report on PPE, and through the audit of NHS National Services Scotland. We recognise that it is important—

Alex Neil: When will you be in a position to tell taxpayers in Scotland what the equivalent figure is for Scotland?

Stephen Boyle: We will be doing that during the spring and into the summer, through two separate outputs. We will report on that as quickly as we are able to.

Alex Neil: I do not find it very satisfactory that the UK NAO was able to come up with a figure so quickly, and yet it will be six, or possibly nine, months after that before Audit Scotland gives us an equivalent figure. Surely you should be moving much faster than that.

09:15

Stephen Boyle: We typically like to base our work on all the evidence, and form judgments in reporting thereon. It may be an option for us to undertake a complementary audit output, as we have done in the paper that we are discussing today. I will take away what you have said and discuss whether there is any scope to accelerate that work and go further on the timescale, and come back to the committee on that. You can rest assured that I recognise the importance of that issue, and we are looking to do the work as quickly as possible.

Alex Neil: I am sure that you realise that it does not look very good that we can get a UK figure in January or February—I cannot remember exactly when it was—and yet we have to wait until July, August, September or October before we get an equivalent figure for Scotland.

I have a similar question on the cost of catching up with the backlog. Unavoidably, a huge backlog of operations, other procedures, appointments and all the rest of it has built up in the NHS in Scotland. For example, it is almost impossible for people with chronic pain to get the injections that they need. That brings an additional cost, because those people are attending accident and emergency departments, which they would not have to do if they were getting their injections as usual. I do not understand why, at this stage in the pandemic, those injections are not available. Are you looking at the cost of catching up with the backlog, and casting a critical eye over areas and health boards that should, by now, be delivering certain services and yet are utterly failing to do so?

Stephen Boyle: Yes—absolutely. That builds on the conversation that we had with the committee about our NHS overview report—[*Inaudible.*]—later on this morning. A key focus of our work is remobilisation, and the implications for the NHS in Scotland of pausing its waiting times improvement plan. We will focus on what that means for the future, in terms of the cost of future delivery and of catching up on the backlog, which will undoubtedly involve significant sums of money, and what that means for the patient experience. All that is part of our plan, and we will report on it as part of our work programme during 2021.

Alex Neil: That is very good. I will pick up on your last point about patient experience. I recognise that, as auditors, your primary focus is the money, but value for money is also an issue. A lot of people are currently very concerned about, for example, a lack of adequate access in some areas to general practitioner services. They do not understand why that should be the case, as it is not as if GPs in Scotland are heavily involved in the vaccination programme. I have already mentioned the dire problems that patients with chronic pain are facing in places such as Lanarkshire, where they are not able to get simple regular infusions and injections. That has resulted in a terrible experience for them, and additional costs for the health service.

When you are doing your work, will you please talk to patients and patient groups, and the cross-party group on chronic pain, to get their feedback on the human cost, as well as the financial cost, to the health service and to others?

Stephen Boyle: I am very happy to make that commitment, Mr Neil. I have had some conversations with the committee already about the fact that—as you will have seen in our plans for our work programme—inequalities and access to services are key areas of our work, through all our reporting.

I am mindful of the committee's feedback to the consultation on our work programme with regard to regional inequalities in access to services. Both those points will be captured in our reporting, and we will be happy to engage with the chronic pain group that you mentioned, and with other interest groups, in order to build those aspects into our understanding so that we have a rounded picture of what remobilisation of the NHS will begin to look like.

Alex Neil: I am sure that groups that represent cancer patients and others will also want to talk to you. That is much appreciated—thank you.

Graham Simpson (Central Scotland) (Con): To go back to Alex Neil's questions about excess costs and the fact that a report was done on that down south, you are aware that this parliamentary session is coming to an end and that the committee has only one more meeting, so is it not possible for you to give the committee an indicative figure within the next couple of weeks?

Stephen Boyle: I would hesitate to be definitive on that. I will look to see whether we have the information and numbers. We are conscious that the evidence supports our numbers. If we are able to do that, we will, but I do not want to give the committee a false expectation, so I will take that away and speak to my colleagues after the meeting to see how our work is progressing before we come back on that publicly.

Graham Simpson: That would be appreciated.

A huge amount of Barnett consequentials have flowed to Scotland, and the chancellor announced extra in the budget. Have you been able to track that money—to follow the consequentials—to see whether it has been spent where it was meant to be spent and, indeed, whether it has been spent at all?

Stephen Boyle: I will ask Fiona Diggle to say a bit about the scale of the Barnett consequentials, recognising the fact that, as I referenced in my introductory remarks, it is a fast-moving and volatile picture. That has been the case over the year, given the sheer number of announcements and the complexity of the money that has already been announced. However, through the paper, we have sought to follow the money and to track what it meant for the timing of the UK budget, the Scottish budget and the spring budget revision. I will ask Fiona to say what our understanding is about the number of Barnett consequentials and

the Scottish Government's commitment with regard to what has been spent and what will be carried forward to next year.

Fiona Diggle (Audit Scotland): The spring budget revision, which came out just after our publication, highlighted that £8.6 billion of Barnett consequentials for this year have been allocated. A further £1.1 million for 2020-21 was released later in the year, and that has been moved forward into the 2021-22 budget.

Graham Simpson: Therefore, that is a total of £9.7 billion in Barnett consequentials.

Fiona Diggle: Yes, that is right.

Graham Simpson: How much of that has been allocated or spent?

Fiona Diggle: The spring budget revision confirmed how much had been allocated and the final budget for the year.

Graham Simpson: What I am trying to get at is how much of the £9.7 billion that is coming or has come to Scotland—it probably has not all come yet—has been spent or allocated? We know that it is here, but has it been spent?

Fiona Diggle: The budget revision showed us what has been allocated to different budget lines, but we do not yet have a complete figure for what has been spent.

Graham Simpson: Basically, we do not know how much of that £9.7 billion has been spent—or, rather, to take the figure of £8.6 billion from before the budget, we do not know what has happened to all that money. Is that correct?

Fiona Diggle: That is right. In our paper, we highlight some areas of spend that the Scottish Government was able to provide figures for on health, and we refer to transport and business spending figures that are publicly available. On that overall picture, the problem has been getting financial information pulled together centrally from a wide range of sources. It is important that that information is tracked and reported publicly for Parliament and the public.

Graham Simpson: It is vital. If that money has come to the Scottish Government, we need to know that it has been used for the purpose that it was meant for and that it has not been stashed away somewhere.

Stephen Boyle: The Scottish Government will be reporting on what it has spent in its consolidated accounts, which are audited each year by us. Those accounts will be the complete record of the £8.6 billion of Barnett consequentials. As you rightly pointed out, Mr Simpson, it has been agreed by both Governments that £1.1 billion of those consequentials from the UK Government will be carried forward into the 2021-22 budget.

As Fiona Diggle noted, this is in effect a kind of live reporting, but the numbers have not yet been audited. We capture in the paper aspects of what we know has been spent, but the definitive picture of what the final number is will come in two stages. One is when the Cabinet Secretary for Finance reports to Parliament on the outturn numbers during the summer, and the second is when we complete our audit of the consolidated accounts in the autumn. That will be the definitive record of the total number that was spent; we will be beginning to report on how well that money was spent. During the 2021 calendar year, we will begin to be definitive about where all the money has gone and how well it was spent.

The Convener: Mark Taylor would like to add something.

Mark Taylor (Audit Scotland): The Auditor General has broadly covered the point that I was going to make, but I will add a bit of colour, if I may.

As everybody on the committee understands, the challenge here is that this has been a moving target as we have gone through the year. What we are able to say is what has been committed—the money that has been earmarked and passed on to bodies, which are then spending or administrating that money. What is more difficult is to get the aggregate amount of how much has been spent by each of those bodies. You will see, from the exhibits in the report, the range of public bodies involved. That is a process that culminates in the preparation of the accounts. As the Auditor General said, that will give us definitive and audited figures.

It is also about recognising the challenge that the Government faces in pulling the overarching picture together, given the information flow back from all the bodies that are spending that money through time, and additions through time. We have done what we can in the report to give a sense of that, but we have to recognise the scale of the challenge. What is fundamentally important, of course, is that money gets to the places that it is needed and that the Government has assigned it to as quickly as possible. We will be able to pick up on that in the course of our continuing work.

Graham Simpson: I suppose that my final question is to ask when we will know what has happened to the money.

Stephen Boyle: It goes back to those two stages, Mr Simpson. We will know what the outturn is when the Cabinet Secretary for Finance reports to Parliament in the summer. We will come in when we have audited those numbers. As Mark Taylor said, that will take place on a wide range of

public bodies. Exhibit 6 in the paper begins to illustrate just how many public bodies are involved in the spending of Covid moneys. There will be an accumulation of reporting through individual bodies, but most important for this committee's interest will be the audited numbers through the consolidated accounts of the Scottish Government. Those two stages feel like the milestones to look out for when it comes to how much has been spent and how well it has been spent.

Bill Bowman (North East Scotland) (Con): Regarding the previous line of questioning, I support the Auditor General for not issuing numbers when he is not happy that he has done all the work on those numbers, even if there is still a wish to get figures out quickly.

Auditor General, the report highlights that information on actual spend is limited. What concerns does that represent with regard to monitoring and auditing public spending? Are appropriate monitoring systems in place? Can you explain how the money goes from the Scottish Government's coffers to wherever it is meant to go? Is it straight out of the Government's bank account, or is it more complicated than that?

09:30

Stephen Boyle: I will do my best, Mr Bowman. I might ask Mark Taylor and Fiona McQueen to contribute as they see fit.

It is complicated. The flow of funds is not what we have typically been used to—[*Inaudible*.]—the distribution of moneys outside public bodies. I will try to illustrate that. Some of the money that we looked to capture in the report was spent by public bodies, but significant amounts were spent on supporting individuals and businesses through grant arrangements, particularly in the early stages of the pandemic. Much of the money was distributed through local authorities or the enterprise agencies. We will audit that through the individual annual audits of the organisations and, to comment on how well the money has been spent, in a series of performance audit reports. As Mark Taylor said, it has been a moving target, particularly as the year progressed.

There are some important safeguards, including monthly reporting through individual bodies, which you will be familiar with from management accounting, progress against grants, spend targets and so forth. It is important that bodies do that monitoring and that the Government tracks what money is spent as it distributes funds to public bodies around the system.

Bill Bowman: Does the Scottish Government regard the money as spent when it pays it to an agency, or does it say that it is spent when the agency says that it has passed the money on to somebody else?

Stephen Boyle: It will be a combination of those things. When the money is distributed by the Scottish Government to public bodies, some say that the money has been distributed. Allocation of the money does not equate to it being spent—that is an important distinction. In the paper, we try to capture that that is not unexpected, to an extent. It is inevitable that there is a difference between the total allocation and the total spend, due to the rate of uptake of the allocation of the funds, whether through businesses or programmes that are anticipated to straddle more than one financial year. Perhaps Fiona McQueen or Mark Taylor will talk to what we understand about how that has been recorded by individual public bodies.

Mark Taylor: I will develop the point that the Auditor General touched on. It depends on the type of funding. The £8.6 billion commitment that we have talked about is broadly a budgeting commitment: the funds have been earmarked and provided for particular initiatives. The extent to which that gets booked as spent, if you like, depends on the nature of the initiatives and the money.

I will give a couple of examples. When additional money is provided to local government through the funding package, the money counts as Government expenditure at the point that it is given; local government goes on to spend it according to its own plans. If money is earmarked for the health service, it is not until the health service has spent the money that the expenditure is recognised. As you know, the accounts are the vehicle for pulling the assessment and information together.

On the broader point, as part of the spring budget revision process, the Government has done an assessment of the expenditure that it expects to incur across the range of its spending programmes. It is not that the Government does not have any information about it, but the Government's assessment is based on the best information that it has available. It is only once we see the accounts that we will know how much of the money has been spent and in what areas.

Bill Bowman: We need to start at the top of the tree in the Scottish Government in regard to how this was set up. If we were looking at another organisation, it would have an agency agreement or a contract on how money was spent and reported. Has the Scottish Government gone through how it can control this and ensure that the money that it has to report on is properly recorded and reported?

Stephen Boyle: You are quite right. There is an onus on there being an understanding of the roles

and responsibilities—[*Inaudible*.]—parties when money is—[*Inaudible*.].

[*Inaudible*.]—importance of the control environment and the governance arrangements—[*Inaudible*.]. We are in the process of doing exactly that through our work, and we will report back publicly to the successor committee on the arrangements that have been put in place to ensure that money has been spent.

As we touch on in our paper, there is a likelihood, given the pace at which money has been spent, that it will not all have been spent as originally anticipated. It is right to recognise that. We will continue to report on how money has been spent but, as I say, given the pace at which money was being passed out and spent, particularly at the height of the pandemic, there is a possibility that not all of it will have been spent well or as originally intended.

Bill Bowman: Will some of that money have gone outside the envelope of the Scottish Government accounts? Would whole public sector accounts help to ensure that all of that is captured?

Stephen Boyle: It will be no surprise to the committee to hear that I am very supportive of that. It feels like it is an essential component of the Scottish Government's public financial reporting to have a complete picture across all public bodies, not just those within the Scottish Government accounting boundary, but particularly—and as you indicate—where local government spending forms part of it. That complete picture of assets and liabilities would be part of the fabric of annual financial reporting. As the committee knows, we are extremely keen for progress to be made on that as soon as possible.

Bill Bowman: Whole public sector accounts are something that we will push.

Gail Ross (Caithness, Sutherland and Ross) (SNP): Good morning, panel. I want to follow up on Bill Bowman's line of questioning. Auditor General, the Convention of Scottish Local Authorities is not here to speak for itself this morning, but I wanted to quote a short passage from a recent press release that came to us regarding Covid spend. It said:

> "COSLA welcomes the £259m non-recurring funding to address COVID pressures next year and the commitment to pass on additional loss of income consequentials. Our ask is that additional COVID money is passed to Local Government with no strings, no reporting, and no questions about the value of essential services provided every day by councils."

What is your opinion as to what that statement means? How do you work with the Accounts Commission to ensure that the money is tracked, as you were describing earlier?

Stephen Boyle: I will take your questions in reverse order. We work extremely closely with the Accounts Commission. The programme of work that I am referring to as following the pandemic pound goes across public audit in Scotland. Audit Scotland is carrying out work on behalf of me and the Accounts Commission to get a complete picture of how the Covid moneys have been spent, regardless of the status of the public body. We have been working very closely with the commission, and I am happy to confirm that.

On the wider point about COSLA's request, I had not seen that quote but, if I heard you rightly, it talked about "no strings, no reporting" on how the money is spent, suggesting that it is for councils to make that determination. I think that it is for the Scottish Government and local government to continue that conversation. Public reporting and transparency are captured alongside that and they are not an impediment, particularly at the height of the pandemic, to getting money to deliver services to individuals and businesses.

The basis of this morning's conversation, and a theme of our paper, is that there is a real need for aggregated reporting and transparency of that money. As far as "no strings, no reporting" is concerned, that will ultimately be a decision for the Government and local government to make together. We would support having clear, line-of-sight transparency, with an ability to make value-for-money judgments at the right time about this significant public investment.

The Convener: If no one else has questions for the Auditor General and his team on the report, I will now suspend the meeting to allow for a changeover of witnesses for the next agenda item.

09:39

Meeting suspended.

09:43

On resuming—

Section 23 Report

"NHS in Scotland 2020"

The Convener: Agenda item 3 is consideration of the section 23 report "NHS in Scotland 2020". I welcome our witnesses, all of whom are from the Scottish Government: Caroline Lamb, chief executive of NHS Scotland and director general for health and social care; Richard McCallum, interim director of health finance and governance; Fiona McQueen, chief nursing officer; and Gregor Smith, chief medical officer.

Caroline Lamb will make a brief opening statement.

Caroline Lamb (Scottish Government): I very much welcome Audit Scotland's report and the opportunity to give evidence to the committee for the first time as the new chief executive of NHS Scotland and director general for health and social care. The Audit Scotland report rightly recognises the significant efforts and dedication of staff in responding to the Covid-19 pandemic, and I put on record my personal thanks to all the health and social care staff who have worked tirelessly over the past year to support our services. Coming into this role, I am reminded daily of the huge contribution that is made by so many, and I am extremely grateful, as I am sure we all are.

09:45

Audit Scotland's findings and recommendations, along with wider scrutiny of the pandemic response, will be fully considered as we remobilise services, address the impacts of the pandemic and undertake future preparedness work.

The report recognises the innovation that has been achieved at significant pace, which we want to hold on to. It also recognises that the swift actions that have been taken across NHS Scotland and by the Scottish Government have ensured that our NHS has not been overwhelmed and that vital services have been maintained. However, as the report sets out, there are lessons to be learned, and I am committed to making sure that we do that.

It is important to recognise that, over the course of the past year, we have been learning, along with the rest of the world, and learning quickly. Today, we still do not understand every aspect of the virus, but we know exponentially more than we did a year ago. As we have understood more, we have had to be agile to adapt and improve our response. We have taken significant steps at pace, treatments have improved, and our prevention and protection measures—including test and protect and our vaccination programme—have been rolled out in a matter of weeks.

Looking ahead, we know that the pandemic will have longer-term implications. Covid-19 has not affected us all equally. It has brought into sharp focus existing health inequalities, and I am determined that we will start to tackle those inequalities in our response to the pandemic. That is central to the remobilisation, recovery and redesign plans that are being developed.

This has been the most challenging of years for the NHS in Scotland, but the service has stepped up time and again, and I am proud to have the opportunity to lead it as we continue to respond to and recover from Covid-19.

I am happy to answer the committee's questions.

The Convener: Thank you. I welcome you to your post, which is crucial in the Scottish Government at this time. I probably speak for the whole committee when I thank NHS staff across the country—who have stepped up in ways that we will probably never know or be able to imagine—for their personal courage, bravery and commitment over the past year. It is almost exactly a year since the country went into lockdown.

I want to begin by picking up on a couple of things that you said in your opening statement. In my time on the committee over the past five years, I have regularly questioned the Auditor General on preventative spend and tackling inequalities. In your opening statement, you talked about tackling inequalities, which you rightly said that Covid has highlighted. We have seen very little progress on a healthier population, improved public health, less obesity and better diet, which, as we have learned over the past year, are very important in withstanding such a virus, but we have known for years—as far back as and, indeed, further back than the Christie commission—that such progress is absolutely necessary. Some would say that it has been political pressure that has forced the Scottish Government to focus on the acute sector of the NHS.

As someone who is new to the job, how are you going to refocus that spend, so that our population is healthier and better able to withstand such a virus in the future?

Caroline Lamb: Thank you, convener. Throughout the pandemic, across the Scottish Government, we have been using the concept of four harms: the direct harm to people who are impacted by Covid; the indirect harm that has been caused by the measures that we have had to take to stand down other services to support our response to Covid; the harm that has been caused to our way of life, our society and our normal way

of living, and the impact that that has had on people beyond their physical health—people's mental health has often been affected; and the harm to our economy.

Addressing all those four harms will be absolutely critical, because health inequalities are just a subset of the wider inequalities across our system. What many of us have found most inspirational in the response to the pandemic has been how people have come together and genuinely united in a single, driving purpose. It will be really important for us to hang on to that, and to the balance of addressing the harms across our society.

You are absolutely correct that we need to look at some of the downstream investment that we can make in order to improve the health and wellbeing of people across Scotland, but we need to do that not simply for the health and social care portfolio; we must look at how we can use investment in the economy and in other areas across the Scottish Government so that we give people the best possible chance of a long and healthy life.

The Convener: I will put the same question to Gregor Smith, once I have expanded on it a little. During my time as an MSP—which I am now coming to the end of—over the past 10 years, the conclusion has been that public health policy is focused on areas in which there is already a lot of harm, such as in drug and alcohol misuse. That is rightly so; however, Government after Government has said that it is committed to shifting spend to prevention, but that has not happened. How can we make that happen? As we move forward, that shift will be critical to making our population more robust against a pandemic such as the one that we currently face.

Dr Gregor Smith (Scottish Government): I agree that prevention is an absolutely critical area, on which we must try to focus as much attention as possible over the coming period.

I will publish my first annual report next week, and it will include a section that is devoted to some of the approaches that we can take in tackling the health and social inequalities that we know exist across the country. We are not unique in that respect. The picture across much of western society is that many of those social inequalities, and the health inequalities that arise from them, have been widening over time, especially since a period in the early 2000s that is associated with the financial crash in 2008. We must try to pick up the pace and address those inequalities with real conviction, and I am delighted that such a collective approach is beginning to develop and that people's conviction when it comes to tackling the issue once and for all is growing.

From speaking to colleagues across the clinical professions, I know that there is a very real realisation that health's contribution to that process, although extremely important, is only part of the story. Recent discussions with the Academy of Medical Royal Colleges and Faculties in Scotland have been very encouraging, in that it whole-heartedly wants to support action in that area. What health can contribute in that area is probably only around 20 per cent of the sum total. A cross-societal approach becomes really important in addressing some of the underlying issues.

I think that we can build and capitalise on some of the changes that have been made within Government over the past year. Improvements have been made through senior professional advisers coming together to use evidence to take forward such an approach. I have developed wonderful relationships with other chief advisers within Government, such as the chief economic adviser and the chief social policy adviser. I think that such joint approaches across Government with regard to the advice that we provide to ministers can help us to make progress in tackling with real conviction some of the deep-rooted issues across our society, so that we can fix the underlying problem of health inequalities.

Colin Beattie: I join the convener in expressing my appreciation for the dedication of, and work that has been done by, NHS staff across Scotland.

However, I would like to look at senior leadership. In the past, the committee has heard criticism about the policy of senior leadership and the turnover of senior leadership. There seems to be have been a slight improvement, which has probably been assisted by a focus on a rather smaller number of shared goals in relation to senior leadership, but the Auditor General said in his report:

> "There continues to be a lack of stable senior leadership, with high turnover and short-term tenure".

That cannot be good. The report says that, since April 2019, there have been turnovers of

> "ten Board Chairs, 14 Chief Executives and eight Directors of Finance",

and that two NHS boards had more than one change of chief executive in the same period.

Caroline Lamb, you are new to the job and there has been turnover of the chief medical officer and chief nursing officer, which does not indicate stability. Can you comment on that?

Caroline Lamb: The NHS is a huge and complex organisation and therefore turnover is inevitable. I highlight the fact that NHS chairs have a maximum term of office of eight years, so included in those statistics are a number of NHS

chairs who reached the end of their maximum term of office. A number of chief executives retired during the period covered by the Audit Scotland report. When people retire, that tends to create a ripple effect, as others move around the system, taking opportunities to move to different health boards or opportunities for promotion.

I will give you some examples. Calum Campbell moved from being chief executive of NHS Lanarkshire to being chief executive of NHS Lothian, thus creating a vacancy and the appointment of a new chief executive in Lanarkshire. Carol Potter moved from being director of finance at NHS Fife to being chief executive of NHS Fife, which created a vacancy for a new director of finance. I am part of the statistics as well, because I came from being chief executive of an NHS board to take up my current post in the Scottish Government.

It is inevitable that we will have movement. It is important to recognise that we have been really pleased with the quality of the candidates for those senior posts, and that is a credit to the work that has been done in areas such as Project Lift to provide development and leadership opportunities for our senior cohort across NHS Scotland.

We provide a huge amount of support and development activity, and over the course of the past year we have been looking at how we need to enhance that, recognising that our new chief executives do not have the informal opportunities to meet colleagues in the same way as they would have done pre-pandemic. We are putting in place revised induction and on-boarding procedures, based on the feedback that we have had from new executives.

If you look at the numbers starkly, they paint a picture that you need to dig underneath a bit. We are seeing absolutely expected retirements and people reaching the ends of the terms of office, but there is a strong pipeline of people coming through to fill the posts, which is welcome.

Colin Beattie: You say that we need to dig beneath the figures, but Audit Scotland has done that and it is expressing concern. It recommended previously that the ideal tenure in post would be five years. Are you anywhere towards achieving that?

Caroline Lamb: I would need to go back to the detail to check the length of tenure. A number of experienced colleagues have moved into posts when they were relatively close to retirement age and then retiring, but that has been done in a way that has helped to develop people in their own system and more broadly. We can look at the detail of that and get more information to you.

Colin Beattie: It would be interesting to see that.

There have obviously been some improvements in leadership, which have been assisted by the move away from the numerous targets set in various institutions and sectors. Has the Scottish Government considered how to revise its current accountability frameworks to see how those could be improved, based on lessons learned from the pandemic?

10:00

Caroline Lamb: As far as learning lessons from the pandemic is concerned, it is still pretty early days for us to start to think about and discuss our decisions on the changes that we have to make.

We have just had a conversation about the need to focus on health inequalities, which will mean thinking about how we measure our performance, the measures that we should use and the targets that we want to set. We will also want to have a conversation with clinicians and with the public in relation to what they expect and what they want to see from NHS and social care services. It is also very much a matter for ministers.

One issue on which we might want to reflect comes back to what I said earlier about the extent to which people have been united round a really common and obvious mission during the pandemic, and the extent to which that has enabled them to be clear about their accountability and responsibility to act.

A lot of factors have grown out of the response to the pandemic, but we are not quite out of that response yet. We will want to take time to reflect on that and be clear about which aspects we want to embed and how we can best do that as we move forward.

Colin Beattie: The Audit Scotland report emphasises the impact of short-term tenure on the stability that is needed for effective strategic planning and reform and for developing effective working relationships. Paragraph 60 of the report mentions the need for collaborative relationships. I do not know whether that is a coded message to us, but it presumably relates to short-term tenure. Do you agree that that is a problem with short-term tenure, and that it needs to be addressed?

Caroline Lamb: I would not link those two aspects of short-term tenure and the development of strong collaborative relationships. One reason for my not making that direct connection is that we in Scotland are fortunate to have a system in which we see people moving from one position to another within and across health boards. I gave examples of that earlier. Therefore, they are all part of what we might call the same ecosystem, and they do not have to start from scratch and build new relationships as they go into a post.

I absolutely agree that collaborative relationships are essential. Such relationships have strengthened hugely. Gregor Smith has just mentioned them in the context of relationships between professional advisers, but the same approach applies across the piece. Different organisations across health boards, health and social care partnerships and local authorities have come together to work, at pace, in a way that we have not seen before. Again, part of that has been about having an absolutely common purpose. However, it is also supported by the regular interactions that we have all had in order to keep the flow of information going. We have seen significant improvements in collaboration in the course of the past year, and we absolutely need to hang on to those and nurture them as we move forward.

Colin Beattie: Clearly, the NHS needs good-quality leadership. The committee has seen repeated failures in leadership in key areas. Progress has been made. How will you harness the good practice in leadership that has been achieved and take it forward, beyond the pandemic?

Caroline Lamb: All the areas that I have just highlighted—collaboration, being clear about priorities and having a single purpose—help leaders to come together. However, over and above those, the learning that has come out of the pandemic will influence our leadership, development and support programmes. We were already working on cross-sector leadership programmes, but as we move forward we would increasingly want to do so, particularly as we seek to address inequalities and to work across all sectors of our society and economy in the way that Gregor Smith articulated.

Colin Beattie: Our successor committee will probably come back to you about those leadership issues in future.

The Convener: Can we have Graham Simpson next, please?

Graham Simpson: You certainly can, convener. I echo the comments of the convener and Colin Beattie by thanking NHS staff across Scotland for all the work that they do.

Can you give us an updated figure on how many deaths there have been from Covid?

Caroline Lamb: I am sorry, but I do not have that in front of me. I will get it for you.

Graham Simpson: Okay. Whatever that figure is, I am curious. When Covid is mentioned on death certificates, is the death always as a result of Covid or is it the case that it is listed if a person had Covid at some point?

Caroline Lamb: I will ask Gregor Smith to speak on the specifics of recording on death certificates. However, the Scottish Government publishes those statistics daily. I will provide an update to the committee once they have been published this afternoon.

Dr Smith: We measure the number of deaths associated with coronavirus infection in two ways. The first is using the figures that are published daily and are associated with a confirmed positive coronavirus test within 28 days. The latest figure that we are able to confirm today is 7,483 deaths.

National Records of Scotland publishes a further measure weekly. Those are deaths where coronavirus has been mentioned on the death certificate. That does not mean to say that the death has happened directly as result of coronavirus, but it might be that coronavirus has been a contributory factor.

The language in the section 2 part, on factors that might have contributed, is important when someone has, perhaps, died of another cause but whose overall condition might have deteriorated because of a contribution from coronavirus. There are nuances in the way that clinicians record deaths on death certificates that are slightly different from those in the data that we publish daily.

We have to remember that some people who die as a result of coronavirus have a long and protracted illness. Some people are ill for some length of time beyond that 28-day period. Those deaths would not necessarily be captured in the daily figures, but they would be captured in the NRS figures that are published weekly.

Graham Simpson: If somebody dies of something else but they have had Covid at some point, are we recording that they died of something else and not Covid?

Dr Smith: On the death certificate, the main cause of death might be noted as something separate from coronavirus, but it could state that it is felt that coronavirus is felt to be contributory in some way. Likewise, when we say in the daily published data that someone has died with a diagnosis of coronavirus within a 28-day period, they might have tested positive in the 28-day period but died for another reason.

That is why the best way to examine the overall tragic impact of coronavirus on our society is by using what is called excess deaths. We have a system in place through which, in regular time, we examine the number of deaths over what we would expect in a given period. Each year, Health Protection Scotland examines those deaths and looks for changes in the patterns, which might happen for a variety of reasons, but which are usually as a result of some sort of infectious agent.

Health Protection Scotland links with other European countries through our surveillance networks to compare experiences.

We will see exactly the same process in relation to the overall impact of Covid-19 and the SARS-CoV-2 virus. The excess deaths will be examined in some detail so that we can accurately chart each country's experience with coronavirus and its impact on mortality among those populations.

Graham Simpson: That is useful, and it takes me neatly on to an area that I want to explore around excess deaths. The Auditor General mentioned excess deaths in his report, and we have seen a large number of excess deaths across the board for a number of conditions, which is a concern. We have also seen waiting times going up, and I wonder whether Caroline Lamb or Dr Smith think that there is a link between that and excess deaths.

Dr Smith: That issue will have to be examined in much greater detail before we can provide that level of specific comment. Many of the deaths that we have seen in the excess deaths category could be indirectly associated with the coronavirus, because of the types of illness that we are seeing that are related to it. That needs further analysis and understanding, which will happen over time. As I said, Health Protection Scotland has a mechanism by which it does that annually and compares with other countries. Undoubtedly, the vast proportion of those excess deaths that, tragically, have been experienced across Scotland over the past 12 months can be directly attributed to the harm that has been caused by the SARS-CoV-2 virus and the Covid-19 infection that it causes.

Graham Simpson: Therefore, those deaths are not the result of the fact that people are not being treated for other conditions. Is that what you are saying?

Dr Smith: No, that is not what I am saying. I am saying that we need to have a much deeper analysis to determine exactly what proportions of the excess deaths have occurred for other reasons, and work on that is under way.

I will give you an example of why that is important. We know that the SARS-CoV-2 virus and Covid-19 can cause lots of complications. Some of those complications might include vascular events, such as stroke and myocardial infarction, or heart attack. That excess death might be attributed to a cardiovascular cause, but we would not be able to directly capture whether someone had decided not to attend health services to seek help for their chest pain or whether it was a secondary complication of a Covid-19 infection. That deeper level of analysis is required before we can fully understand the relative contributions for each of those issues.

Graham Simpson: On waiting times, my concern—I am sure that it is a concern for you all—is that, as we emerge from the pandemic, there will be a lot of people who have not had the treatment that they would ordinarily have had, so there will be quite a backlog. Can you give us a flavour of the scale of that and how long it will take you to get through things?

Caroline Lamb: There are two parts to the current backlog. As we start to remobilise services, there is the backlog that we know about, which is the number of people on waiting lists. Just like when we were able to remobilise services back in the summer, we are conscious of the requirement not only to treat people but to do so in a priority order, so that we are prioritising people in greatest need. At the end of February, we received remobilisation plans from all our NHS boards, and we are in the process of working through those.

10:15

We also need to take account of what you might call the unrecorded backlog. The Audit Scotland report mentions the fall-off in presentations. We have been looking at the details and we are still working through the data to understand what it might mean about demand that has not yet presented itself.

The position is that we have received remobilisation plans from all NHS boards, which look at how we can start to remobilise services during 2021-22. A lot of it will depend on the progress of the pandemic, and we will need to retain in place all our measures to combat the pandemic.

The other element of that is being mindful of the level of exhaustion among our staff. As everybody on the committee recognises, NHS and social care staff have done a tremendous job over the past year, which has been at some significant cost to those individuals. We are particularly conscious of a backlog of untaken annual leave. We need to ensure that, as we start to remobilise services and recover the position, we do that in a way that enables staff to recover, and to take some downtime and some of the annual leave that is due to them. We are not yet in a position to be clear about exactly how long we expect that to take and, as I say, it will be very much influenced by the progression of the pandemic, but we are working through those plans at the moment.

Graham Simpson: Are you able to say whether there is a six-month backlog or a year's backlog across Scotland? I appreciate that it is different for different health boards and indeed for different

conditions. Are you in a position to give us that sort of figure?

Caroline Lamb: At a granular level, we are aware of how many people are waiting at different levels, but I would not want to give the total figure for Scotland, because that disguises different specialties and people who are in different priority categories, and it does not yet address the picture on people who we think we have missed because they have not presented.

Graham Simpson: In the Auditor General's report, he says that the Government and NHS boards should monitor the impact of people avoiding attending their GP or hospital and that action should be taken

"to mitigate any adverse impacts"

of that. What is the current rate of people who say that they will not go to a GP or hospital, for whatever reason?

Caroline Lamb: We monitor that through polling. In the most recent poll, which I believe is from 5 March, people were asked whether they would be too concerned to present to a GP practice if they had something serious that was unrelated to Covid. Sixty per cent of people disagreed with that statement, which would imply that 60 per cent of people felt comfortable. Twenty-five per cent of people agreed with the statement and were therefore still cautious. Within that 25 per cent, I think that 7 per cent agreed strongly with the statement. The position is shifting, and more people are prepared to come forward. You will be aware that we continue to run quite a significant campaign about the NHS being open, in order to encourage people to present who may have conditions that absolutely need to be checked out.

Graham Simpson: I think that a different question should be asked. Instead of asking whether someone would go to the doctor or hospital if they have got something seriously wrong, they should be asked whether, if it is just a minor ailment, they feel that they do not want to bother the doctor at this time, or that there is no point.

Caroline Lamb: That is a legitimate question. I guess it comes down to people's individual judgments about what is minor and what is major.

Starting in winter 2020, we were able to implement our redesign of urgent care, so that we could clinically triage people who would otherwise present at A and E. That was partly about ensuring that we did not experience overcrowding in A and E, given all the issues around social distancing.

There is a well-established service. People who have concerns can get in touch with NHS 24, through the 111 line, to be triaged. Through that procedure, it is determined whether their issue can be dealt with by a pharmacist, or whether they need to present to a GP or require urgent care.

Dr Smith: It is important to make sure that people feel comfortable and able to access services when they need them, for whatever reason. The perception of need is an important part of the question that Graham Simpson asked. We have tried to ensure that people can access services by various different mechanisms, so that they feel wholly comfortable in doing so.

First, we need to ensure that, in the primary care environment, where 90 per cent of all consultations take place, there are separate pathways for people who may be infectious and suspect that they have Covid, and those who need care for other reasons. GP practices have remained open, albeit that they have been providing care in a slightly different way from what they were used to. They still do face-to-face consultations where that is necessary, but people are able to access consultations and see clinicians with whom they are familiar by contacting the practice by phone, or by using the wonderful new NHS Near Me technology. That has been a revelation during the pandemic—it has enabled so many people to access services safely in a way that suits them and which removes the need for travel while allowing their conditions to be properly and safely assessed.

Near Me has been one of many technological innovations during the pandemic, and it is a positive attribute of the way in which we deliver care in Scotland. Again, I emphasise that, if people are feeling apprehensive about attending consultations in person, they can use that technology to get the advice that they are seeking in a way that suits them.

Gail Ross: I put on record my thanks to all the staff in the NHS who have worked so hard and continue to do so.

My line of questioning follows neatly on from what has been said. In the Highlands, we are very proud of NHS Near Me, which started up here. I am from Caithness, and the service has reduced by a lot the number of trips that I have had to take down to Raigmore. I am proud that it is now being used in such a vital way across the country.

The Audit Scotland report states:

"the Scottish Government"

has

"committed to review and develop the role of the … assessment hubs and virtual appointments".

In our evidence session with the Auditor General, the issue of safeguarding was brought up. It was

emphasised that people should not be dissuaded from making an in-person appointment if that is best for them, and an important point was raised about the need to maintain patient privacy. What safeguarding and equalities measures will be considered as part of the review of the videoconferencing service?

Caroline Lamb: I echo what Gail Ross has just said. Highland was one of the early adopters of the Near Me service, and it has led the way on that. Over the past year, it has been great to see Near Me move away from being seen as a bit niche for remote and rural areas to sit far more at the heart of our services.

There was an evaluation of Near Me that predated the pandemic, which reported in June 2020 or thereabouts. We commissioned a further evaluation to take into account the rapid scale-up of Near Me throughout the pandemic, and it is due to report at the end of this month. The evaluation has examined some key issues. The first is the need to be clear about when a remote consultation is clinically appropriate. There are some aspects of consultation that it would not be appropriate to do remotely, or where remote consultation would need to be supplemented by ensuring that the GP or consultant can access data from an individual's monitoring device, for example. Equally, there will be areas where remote consultation is entirely appropriate.

The evaluation noted that, in general, the quality of the technology platform is high. There is huge value being reported in terms of a reduced risk of infection, a reduction in travel and opportunities to think about delivering services in a very different way. I note that we have gone from around 300 virtual consultations a week in early March last year to more than 22,000 a week now, which represents significant progress.

However, concerns have been raised about inequalities in access. That is partly about whether people are digitally connected, and partly about information technology literacy. In addition, as Gail Ross mentioned, lack of private space can be an issue. That chimes with the equality impact assessment that we published in September 2020, which recognised that there will be key groups of people, such as those who are in difficult domestic circumstances, for whom home consultation may not provide the privacy that they require. It is essential, therefore, that we retain the face-to-face option.

As we move forwards in thinking about how remote consultation can be used to support the remobilisation and redesign of services, we could look at other ways in which we can provide remote consultations. For example, people might be able to go to a local community centre to engage in a remote consultation with a consultant who is at the other end of the country. There are things that we can do to balance those issues, but we would never want to say that people can access consultations only remotely. We will always need to retain face-to-face consultations; I am sure that Gregor Smith would support that view.

Finally, it has been great to see the Near Me service rolled out in care homes. Other digital technology, such as VCreate, has also been used to enable people, in particular those in intensive care, to keep in touch with their families through a videolink, at a point when families have not been able to visit. There has been a huge amount of innovation in that regard, but we are mindful of the issues around safeguarding and equality.

Fiona McQueen (Scottish Government): I agree with what Caroline Lamb said about safeguarding. At times, a digital presence may not allow the practitioner to make a full assessment, in particular with children and young people, but with older people too. There may be issues of coercive control or harm that would not necessarily be picked up. Nevertheless, I reassure the committee that the policy teams and the practitioners now have a year's worth of evidence on that. The digital option has been amazing for a lot of people, but the fact that in-person consultation by a registered practitioner may be required, or may at least be helpful, is noted. Practitioners are aware of safeguarding issues that may be masked by digital consultation. The multidisciplinary and multi-agency teams are very much alert to and aware of that, and are taking it into consideration.

Dr Smith: I have one final word on this, which is just as important. First, I emphasise that—

The Convener: Sorry—can I interrupt? I am not hearing you very well. Could you sit forward a little bit, or nearer your microphone, please? I am struggling to hear you clearly.

Dr Smith: I hope that you are hearing me now.

The Convener: That is a little bit better.

10:30

Dr Smith: I will continue. One of the points that we would want to emphasise about NHS Near Me is that it is an option and not a replacement.

Perhaps a hidden benefit of it, which people do not realise, is that as we look forward to the 26th United Nations climate change conference of the parties—COP26—which Scotland will host later this year, its use can make contributions towards climate change. The NHS Near Me service in Scotland has now saved approximately 28 million miles of travel for people who use it, which is a fabulous contribution to reducing the impacts of climate change.

Gail Ross: That is a good point. Thank you. I will move on to a new topic. [*Interruption*.]

The Convener: Excuse me, Gail. Can I interrupt for a minute? There is disturbance on the line and we are not getting a clear feed. I ask broadcasting colleagues to advise me where the problem might be. I am told that that is being investigated.

Have the official reporters managed to get everything that has been said in the past couple of minutes? [*Interruption*.] I will take that as a yes.

I am sorry to have interrupted you, Gail. Please continue.

Gail Ross: No, that is okay. I was struggling a wee bit there as well, convener. Thanks for that.

I want to ask about PPE. As a constituency MSP, I was contacted quite often about whether staff had what they saw as the correct PPE and about the amount of PPE that was available to them. The report refers to findings from the British Medical Association's survey of its members, including that 16 per cent of respondents highlighted lack of access to correct or sufficient PPE as their most concerning issue. The Royal College of Nursing's survey found that, of those working in higher-risk environments, 25 per cent had not had their masks fit tested and 47 per cent had been asked to reuse single-use equipment, which I am sure that you will agree is very concerning.

Is any work being done, or is any planned, to assess the impact of such issues both on staff and on patients? How will the Scottish Government assess that in a meaningful way?

Caroline Lamb: I will start off on that and then I will bring in Fiona McQueen, particularly on infection prevention and control and on how guidance on the appropriate standard of PPE is developed.

Clearly, we have seen unprecedented demand for PPE during the pandemic. In Scotland we are fortunate in having a single national organisation—NHS National Services Scotland—responsible for the procurement of PPE and the maintenance of the pandemic stockpile. We moved very quickly to ensure that NSS was able to support not only NHS boards but primary care and social care organisations including care homes.

However, as I have said, the demand was unprecedented: Audit Scotland noted that in early February 2020 NSS was shipping around 97,000 items of PPE, but by early April that was up to 24.5 million items. As for specialist equipment, the numbers of FFP3 masks shifted from around 2,000 per month to 1.8 million. We were fortunate in that we did not run out of PPE, but we recognised that we had to take swift action to improve distribution chains. That included setting up PPE hubs across the country. NSS also instituted a portal through which boards could report any issues with PPE.

On the standards of PPE, all PPE must be assessed by the Health and Safety Executive for appropriateness. The other issue is fit testing at a board level. Through the pandemic, we have learned that there is a requirement to be agile and to respond quickly as issues occur. As part of that response, NSS provided 40 fit test machines to our NHS boards, which rapidly scaled up our ability to effectively and efficiently fit test staff for masks. It is a complex area, because there are different types of mask that need to be fit tested. They fit differently on different faces and, although someone might have been fit tested, if their face changed—if they removed facial hair or if they lost or gained weight—they would need to be fit tested again. It is very complex.

As part of our preparedness in future, we would definitely want to focus on boards being able, through the use of fit test machines, to rapidly fit test staff, who are often redeployed from areas where they would not have required to be fit tested. Fiona McQueen might want to say something about the development of guidance and vigilance with regard to which PPE is appropriate for which roles.

Fiona McQueen: In Scotland, we are fortunate to have an internationally recognised infection prevention and control manual that is evidence based and which gives people the advice that they need on what PPE is required. There is no doubt that staff were under huge pressure, and there was a lot of anxiety about it. Gregor Smith has already talked about the fact that this was an unknown virus and we were uncertain about what it would do. Across the UK, we developed and agreed infection prevention and control guidance, which was issued in early April to emphasise and supplement what was already there. There was clearly anxiety from staff about whether they would need to wear a face mask and whether they would need that additional protection of a filtered face mask. Communication was very important, so that people knew what PPE they required.

There is no doubt that, at times, some people believed that they needed additional levels of protection to what the evidence suggested. They were not blameworthy. People were anxious and they were worried about treating people with Covid-19 and taking it back to their families, so we needed to work hard to explain and enable people to understand and to have confidence.

In the guidance that we issued in April, although we said that it was not required for staff who were not working within 2m and whose patients or—if it was social care—clients did not have Covid, we said that, if those members of staff wanted to wear

a fluid-resistant surgical face mask, they could. We tried to be as facilitative as possible.

Again, we did not run out of PPE in Scotland, but there is no doubt that there were times when distribution, particularly to our care homes, was tight. The employer has the responsibility to provide PPE and, until we took over responsibility for providing that in care homes, that was the situation with distribution. My nursing and medical colleagues in our big hospitals would also say that, when a big delivery arrived, there was a lot of relief that the PPE would be there for people.

We are continuing to look at the evidence to determine whether our current PPE is right and proper. We have also produced guidance on how we care for people with Covid-19 or suspected Covid-19 as well as advice on how we care for people who do not have Covid-19, through the red and green pathways, as we remobilise the NHS. We gave people working in the green pathways discretion to wear filtered face masks if they were carrying out procedures that would require those face masks in the red pathways. We were facilitative so that we supported those who wanted to do that.

We need to constantly communicate and listen to staff, and our professional organisations are incredibly helpful in that. We work in partnership with them to get an understanding of what staff are finding challenging and what they are afraid of, so that we can respond. We are developing a series of webinars so that grass-roots staff can have full access to talk to the experts about what their concerns are, what they want to see developed and moved forward, and how greater assurance and advice can be provided.

We did not ask people at any time to reuse single-use PPE. That happened in other parts of the United Kingdom. We recognised that other parts of the United Kingdom were doing that, but we were never in a position in which that was required. Visors are manufactured to be reusable, and we gave instruction on how to appropriately use them. Similarly, there was sessional use. Normally in a surgical ward, a person would put on a mask to treat one patient but, with Covid-19, the expert advice was that there could be sessional use if that was wanted.

Some of the communication got mixed up along the way, and we have absolutely learned from that. We have provided posters, and we are working hard. We hope to have dialogue with the widest group of staff across Scotland in webinars, but we are constantly keeping that under review.

Gail Ross: That is reassuring. Thank you for that clarification.

Just in case I do not get to speak to you again, Professor McQueen, I wish you all the best in your future endeavours, and I thank you for all your work.

I direct my final question, which is about the manufacture of PPE in Scotland, at Caroline Lamb or Dr Smith. I believe that we had a target of 90 per cent of PPE being manufactured in Scotland by this month, excluding gloves. Do you know where we are on that aim? Has it been achieved yet?

Caroline Lamb: If we exclude gloves, we have hit 90 per cent. I believe that, if we count in gloves, the figure is around 50 per cent.

Gail Ross: Excellent. Thank you.

Alex Neil: As an ex-health secretary, I am very proud of how the national health service and social care services have responded to the pandemic in Scotland. It has been outstanding, and everybody should be proud of what they have done.

I reiterate what Gail Ross said. I wish Fiona McQueen all the best in her forthcoming retirement after many years of service to the national health service. I also congratulate Caroline Lamb on her appointment—I have not spoken to her since she was appointed—and I congratulate Gregor Smith on his appointment.

I want to ask about capacity. There are huge pressures on the national health service at any time, but Covid, long Covid and the backlog that has already been discussed add to them. I know that you cannot be precise at the moment, because you are gathering together the data, as was said earlier, but what worries me is the capacity in critical staffing and finances to address all those issues at once. All of them will need to be addressed simultaneously, and that is a huge challenge by any standards. Will you say something about the scale of the challenge and the capacity issues that you will face?

Caroline Lamb: Yes. Thank you very much for that.

We have already had a conversation in the committee about the backlog in waiting lists and the unmet demand. It is clear that that is one category.

Alex Neil highlighted long Covid, which Gregor Smith may want to come in on. Obviously, we are still learning about what the impact of long Covid is likely to be and therefore what the health service is likely to need to provide. We are conscious of the impact on mental health and wellbeing in our own workforce and also across wider society.

We have also stood up a substantial test and protect operation, and we have a significant on-going vaccination programme—indeed, it is the biggest-ever vaccination programme seen in Scotland. Alex Neil's questions about capacity are

therefore well made. Early in the pandemic, we were hugely successful in attracting returners and retirees We also managed to deploy student nurses during the first wave, which helped us get through that wave.

10:45

Alex Neil is right that we are still working through the detail of how we remobilise services as we come out of the second wave and what we do in the longer term, but we can give the committee some clear indicators of where we are heading. We are clear that we need to support our workforce and retain as much of our workforce as possible to continue to support us in remobilising services. In the work that we have done on the mental health and wellbeing network and the investment that we have put in to supporting people, we have been trying to ensure that our workforce feels properly supported and therefore that we retain people.

The test and protect workforce, particularly the contact tracing workforce, has been a different sort of workforce, so we are trying wherever possible not to draw on registered clinicians for that work. Increasingly, as we move through the vaccination programme, we do not expect it to be a one-off; we expect to have to come back with boosters, so we are looking at how we can deploy a different sort of workforce to support that. At the moment, we are able to draw on the workforce from across many services but, as life gets a bit more back to normal, that will not be the case.

The other thing that is very encouraging is the number of applications for undergraduate courses. Clearly, the people will take some time to come through, but it is welcome to see that applications for undergraduate nursing courses are up by 28 per cent, and that 37 per cent of those applications are from mature students. We have a huge opportunity there to develop the workforce that we are going to need for the future.

However, your points are very well made. We will need to look at how we deploy our workforce most appropriately, and that is not just about remobilisation and recovery. Part of that redesign work is also about ensuring that we can use the workforce that we have as effectively as possible and where they add value. Using things like remote consultations, for example, to help to release staff time is really important as part of all that.

Alex Neil: I want to ask you about use of new technology such as robotics and artificial intelligence, particularly for diagnosis. We have seen fairly exciting developments in robotics and artificial intelligence and, indeed, in many other fields of innovation and technology relating to health. How big a part can that play? As we know, with some of the artificial intelligence that has been developed, some diagnoses can be done more accurately and much more quickly than they can be done through normal channels. Are you looking at how particularly robotics and AI can be used as well as other new technologies?

Caroline Lamb: We are absolutely looking at where the opportunities are to deploy robotics and artificial intelligence to support us. Artificial intelligence can be used in many ways, including to support diagnostics and other measures on the front line. It can also be used to speed up some of our administrative processes and to ensure that, for example, we are able to communicate more effectively with patients. Some work is being done in NHS Lothian on using artificial intelligence to triage GP referrals. There is a huge amount of opportunity in that.

Gregor Smith might want to say something about the clinical opportunities in this area.

Dr Smith: This is an exciting area for clinical practice. We are seeing the creative disruption of the way we used to do things and new technologies being brought in to assist us either to make a diagnosis faster or to be more confident in our diagnosis.

That relies on a base of good data. Members might be aware of the health and social care innovation Scotland partnership, which is led by our chief scientist, Professor David Crossman. In future we will see much greater use of the innovations that are emerging from that group, for example in the diagnosis of skin and eye lesions. Our current approach should be about building the governance and the processes around that work, to ensure that we are absolutely confident that it will do what it intends to do. However, the data that we are currently seeing coming through from such innovative projects will vary from region to region.

I will pick up on Caroline Lamb's point about our future workforce needs. Mr Neil mentioned the work that our NHS and social care staff have been doing across the country for the past year. I firmly believe that that is having an inspiring effect on attracting people into the profession. I have recently seen data that shows that applications from Scotland-domiciled students for medical and dental places at Scottish universities are up by 23 per cent. It is wonderful to see that people are grasping the opportunity to take up careers in those areas. We need to ensure that, in the process, we attract people from right across the social spectrum who have the ability to enter such courses. To go back to our earlier discussion, that will also be a sure-fire way of beginning to reduce any inequalities that we see across Scotland. We must build on the good work that has been started

and which, in the future, will allow us to ensure that the health and social care workforce comes from as wide a grouping of society as possible.

The Convener: On that point, have you done an analysis of the social backgrounds of applicants to medical schools? One of my concerns, which I have raised in Parliament many times, is that we cannot get GPs to staff surgeries in our most deprived communities. That is an issue in Dundee, and I believe that it is a problem in Fife and other places across the country. Has the Scottish Government carried out such analysis? There will be an impact eight years down the line, when people qualify and then choose where they want to work. We will need people who want to serve their own communities.

Alex Neil: Convener, may I add to that before Dr Smith answers?

The Convener: Yes.

Alex Neil: The same concern applies to deprived and rural areas. All the evidence shows that, historically, trainees who come from rural areas of Scotland tend to go back into those areas much more than graduates do on average. They do not necessarily go back into the areas that they came from, but they go back into rural areas. For people such as Gail Ross, who lives in Caithness, that is critically important.

The other aspect is that we must ensure that when those new entrants eventually graduate, as many of them as possible stay in Scotland. Many go furth of Scotland and are lost to us forever.

The Convener: I have a couple of direct questions on that point. Has the Scottish Government carried out an analysis of the social backgrounds of new applicants? If so, could the committee have a copy? What is the current percentage of medical graduates whose studies have been paid for by Scotland who are leaving Scotland to work in other health systems? I have been trying for years to get a figure on that. I believe that the number of newly qualified doctors that we are exporting is currently as high as—or higher than—40 to 50 per cent.

Dr Smith: I will take those issues in turn. First, I agree that it is absolutely imperative that we expand the opportunities for people from all backgrounds to pursue careers across the health and care professions, whether they be medicine, nursing or any of the numerous types of—

The Convener: I know that you will agree with that statement, but could you answer my question? Have you done such an analysis of the backgrounds and geographical areas of new applicants to medicine? Is that available?

Dr Smith: I do not have with me the current data from the Universities and Colleges Admissions Service on new applications, but I can seek to find out, from those working in the relevant policy area, whether we have that information and share it with the committee.

The Convener: You do not know whether we have got it at the moment.

Dr Smith: I am not aware of whether we have it, but I can check with those in the policy area to ensure that, if it is available, we can share it with you.

Caroline Lamb: I want to add to that. Gregor Smith and I can provide a further briefing to the committee on that, but I will note that, over the past few years, the Scottish Government has invested in additional medical schools places, with a focus on widening access. There has been a clear commitment from the Scottish Government to ensure that students from more disadvantaged backgrounds have routes into medical school, because we recognise how important that is.

On your question about Scottish students who train in Scotland and then leave, I think that we can provide that information to the committee. Although I have not looked at the data lately, my recollection is that graduates might choose to leave for a period but that we have quite a good track record of attracting them back to Scotland. However, we will provide that data. People might choose to leave to work somewhere else, but, as Mr Neil referred to, people tend to migrate back to where they came from, which is why it is so important that we have high numbers of Scotland-domiciled students in our medical schools in the first place.

Alex Neil: May I—

The Convener: No. Bear with me, Mr Neil.

The last data on that that I looked at showed that Scotland has a far higher attrition rate of medical students who qualify and then leave than English and Northern Irish medical schools have. You might be right, Caroline Lamb, that they are coming back, but that data is not available from the Scottish Government. In all my time in Parliament, the Scottish Government has never been able to provide that figure, but universities and others tell me that it is 50 per cent, which is a huge investment of taxpayers' money. It costs more to train doctors than people in any other profession. The Scottish Government is paying for that, and then we are losing these young doctors—up to 50 per cent of them—who are prepared to work perhaps longer hours in their early 20s. However, the Scottish Government has never been able to confirm that. If you can confirm that to the committee before the end of this parliamentary session, I would be very grateful.

Alex Neil: Thank you for using up most of my time. I have one final question. I want to go back to Caroline Lamb about the capacity issue and all the challenges. I understand that this is a moving target, but, as things stand, when would you expect the national health service, particularly the acute sector, to get on to a post-pandemic even keel? That is a difficult question, but will it be this calendar year or is it likely to be next calendar year? Might it take two, three or five years to get back to where we were pre-pandemic?

Caroline Lamb: I understand that you want to be able to be clear about dates and times, but that is really hard. It is difficult in terms of understanding the precise nature of the backlog—both the backlog that we know about and the unknown backlog—and because we do not know what is going to happen with the pandemic and what its impact will be. I am not going to commit to absolute time periods on that, and I do not think that you will be surprised to hear me say that. We will not get back to a steady state and to where we were pre-pandemic in the current financial year—it will be beyond that—because, as I have already said, quite apart from the issues around continuing to manage the pandemic and what that means with regard to social distancing, cleaning and the extra time that it takes to don and doff PPE, we need to ensure that this year's staff take the leave that they are entitled to.

Alex Neil: When you say "current financial year", I assume that you mean the new financial year that starts in April.

Caroline Lamb: Yes. I am sorry.

Alex Neil: We do not expect you to be back on an even keel by 5 April.

The Convener: I will finish with a local question. Gregor Smith and Caroline Lamb might be aware that a couple of weeks ago, the chief executive of NHS Tayside told the committee that he cannot guarantee the future of the breast cancer service for women in Dundee. I raised that issue with the First Minister last week, and she said that she would get back to me. I have not heard anything yet. What work is on-going to guarantee the future of that service for women in Dundee?

11:00

Caroline Lamb: I had a conversation with the chief executive of NHS Tayside this week, and John Connaghan, who is the chief operating officer of NHS Tayside, will meet the chief executive and other colleagues next week as part of the examination of its annual operating plan. The first thing on the agenda is to get an absolutely clear understanding. From the conversation that I had with the chief executive this week, I am aware of the efforts that the board has gone to to attempt to recruit new consultants into its breast cancer service and work that is going on to look at what mutual aid can be provided across boards in the event that that recruitment is not as successful as we would want it to be.

We will pick up that issue. As I have said, I have picked it up with the chief executive this week, and there will be a follow-up conversation next week. We are absolutely alert to those issues, and we are following them up.

The Convener: Thank you for that update. I am going to follow that up with the First Minister, and I hope to hear back from her directly on it.

Alex Neil and I were keen to ask about the attrition rate, and I do not think that Gregor Smith got a chance to talk about that. Do you know what the current attrition rate is for newly qualified doctors going from Scotland to other countries?

Dr Smith: I do not know what the current attrition rate is. It has been some time since I looked at that data. However, if it is available, we can pass it on to the committee.

The Convener: It must be available, because universities have quoted it to me. I am sure that the Scottish Government must have that figure. It would be really helpful if we could have it.

Bill Bowman: I echo my colleagues' appreciation of the NHS staff and their sacrifices in this period.

I think that Caroline Lamb said that the NHS is huge and complex, and she spoke about the NHS being agile during the pandemic and getting organised through it. We have heard from others, including Alex Neil, that some organisations in the NHS have been the subject of reports by the Auditor General that have said that the management has not been so wonderful. I think that you said that you were looking at 20-plus plans for the remobilisation—no doubt they are for the health boards and maybe the other national parts of the NHS. Can you give us some comfort that it is not a case of their simply telling you what they want to do? I expect you to be directing them. To be honest, constituents who contact me ask about when they will get their treatment, not whether there is a nice plan. Things build up, and we review, set up a committee and look at things. How do you keep the focus on clinical execution as opposed to process?

Caroline Lamb: On prioritisation and being really clear about having a consistent approach to how we prioritise the treatment of people who have been waiting, in November 2020 we published a clinical prioritisation framework, which is clear about the different priorities that we accord to people who are waiting. We are also very clear

about the need to keep that under review, because the priority accorded to some people might change.

In December 2020, we issued comprehensive guidance to NHS boards on the production of their annual operational plans for 2021-22. The review that is currently going on is very much about ensuring that the things that we would expect to be consistent across the country have been addressed by boards, although it is accepted that there will always need to be some local variation, depending on geographies and other issues.

It is not just a question of boards telling us what they want to do, but very much a question of us giving boards a structure, a framework and priorities within which to develop plans and our reviewing those plans against the structures and priorities.

Bill Bowman: As you settle into the role—you are not new to the organisation—are you finding that the structure is cumbersome and inhibits you from getting things done?

Caroline Lamb: No, I genuinely am not. We are fortunate that Scotland is of a size that means that we are able to get the right people in the right virtual rooms these days to have the conversations that we need to ensure that we are able to take forward the Scottish Government's priorities. That has been amply demonstrated in the response to the pandemic. As I said in my opening statement, I welcome the fact that Audit Scotland has acknowledged how NHS boards and the Scottish Government have responded at pace. That is an illustration of how the whole system absolutely comes together to make something work.

It is important that boards understand their local demographics and the issues in their local populations, and that they are in a position to respond to those.

Bill Bowman: I would be a supporter of localism. The issue is the balance between that and being agile. I wish you well in that. I will not be here to see what you do.

Caroline Lamb: Thank you.

The Convener: I thank all the witnesses very much for appearing in front of the committee. I know that this a very challenging time for the NHS. I wish Gregor Smith and Caroline Lamb the very best in their roles, and I wish Fiona McQueen a very happy and restful next chapter. Thank you for all your work.

I close the public part of this meeting.

11:06

Meeting continued in private until 12:03.

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