OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 8 September 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 8 September 2022

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COVID-19 RECOVERY COMMITTEE
19th Meeting 2022, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Graham Foster (Scottish Directors of Public Health Group)
Carolyn Low (NHS National Services Scotland)
Mary Morgan (NHS National Services Scotland)
Dr Nick Phin (Public Health Scotland)
Richard Robinson (Audit Scotland)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

Committee Room 6

Scottish Parliament

COVID-19 Recovery Committee

Thursday 8 September 2022

[The Convener opened the meeting at 09:30]

Pre-budget Scrutiny 2023-24

The Convener (Siobhian Brown): Good morning and welcome to the 19th meeting in 2022 of the COVID-19 Recovery Committee. The committee has agreed to focus its pre-budget scrutiny on how the Scottish Government plans to fund its Covid recovery strategy and the on-going costs that are associated with the pandemic, as set out in the Covid-19 strategic framework.

Today, we will focus on the strategic framework. I welcome our witnesses: Richard Robinson, who is a senior manager at Audit Scotland; Mary Morgan, who is chief executive, and Carolyn Low, who is director of finance, at NHS National Services Scotland; Dr Nick Phin, who is the organisational lead for strategic engagement and policy at Public Health Scotland; and Dr Graham Foster, who is director of public health at NHS Forth Valley and chair of the Scottish Directors of Public Health Group. Thank you for giving us your time this morning.

Each member will have approximately 15 minutes to ask questions. We should be okay for time, but if time runs on too much, I apologise in advance for having to interrupt members or witnesses in the interests of brevity. I ask the witnesses to briefly introduce themselves and their organisations.

Richard Robinson (Audit Scotland): I am a senior manager at Audit Scotland. During the past couple of years in particular, we have looked at the Covid-19 pandemic from the finances side. I am part of a public finances team that looks at things to do with the operation of the fiscal framework and the Scottish budget.

Dr Nick Phin (Public Health Scotland): I am director of public health science and medical director for Public Health Scotland. I started in January 2021, so I am fairly new to PHS. I had been working in Colindale in London as deputy director for the national infection service, so I have come back home, so to speak. I will try my best to answer questions, but if I can provide any information about the time prior to my appointment, I will be happy to submit it as written evidence afterwards.

Dr Graham Foster (Scottish Directors of Public Health Group): Good morning. I am a public health doctor. After originally training as a general practitioner in 1992, I then trained in public health. I have been a fellow of the Faculty of Public Health since 1997. I did four years as a senior medical officer in public health policy for the Scottish Government, and I have been at NHS Forth Valley as a consultant since 2001, and the director of public health there since 2014.

I am also the current elected chair of the Scottish Directors of Public Health Group, which is a voluntary network of the 14 directors of public health who sit in the territorial boards in Scotland. We were part of the front-line response to Covid in Scotland. Although I am able to represent the views of that group, I am not formally a part of it and it is not a legal group, so my views today will be largely my own. However, I can help the committee to understand what I believe the collective views of the group would be.

Mary Morgan (NHS National Services Scotland): I am the chief executive of NHS National Services Scotland and have been so since 1 April 2021. I have a long career in the NHS in Scotland in a variety of roles. As I am sure that members know, NHS NSS provides a variety of national and shared services to the NHS in Scotland.

Carolyn Low (NHS National Services Scotland): I am director of finance for NHS NSS, and I have been in post for eight years. I am also the chair of the directors of finance for the national boards, so I can bring an NHS NSS and a PHS perspective to the committee today.

The Convener: Welcome, everybody. We turn to questions. I will ask the first one. What particular areas of Covid-19 spend would you prioritise at the moment? We will start with Dr Phin.

Dr Phin: There are probably two main areas. One is vaccination, because vaccination services remain at the heart of the response, provide protection and mitigate severe disease and death. We started the vaccination of people for Covid and flu a week ago, so that process has started. Vaccination will be key for both current and future protection.

The second main area is testing and surveillance. The surveillance function will be really important to help us understand what is happening across Scotland, to give an indication of a potential resurgence of a new variant or a new mutation, and to allow us to take the appropriate response. Surveillance will also give an indication of severity. For instance, omicron was highly infectious but, in retrospect, we know that it was probably 50 per cent less severe than delta, which was the strain that preceded it. Having that understanding and insight is really important.

The surveillance function also extends to other respiratory infections, because we have syndromic surveillance, which involves general practitioners and emergency departments reporting respiratory illness. It is important that we understand how much of that is attributable to flu, Covid and so on, so that we know whether our strategies and responses are effective. Those are probably the two key areas that we would want to focus on.

The last area would be preparedness around a future pandemic. I am a member of the Scottish Standing Committee on Pandemic Preparedness and was involved in the interim report that was published last week. Those would be my priorities.

The Convener: We have a large panel this morning. Does anybody want to add to that?

Dr Foster: I am in danger of saying, "I agree with Nick," a lot this morning; I will try not to do that. As a representative of the directors of public health, I want to add to what Nick said and stress the importance of robust and resilient front-line public health teams in our 14 national health service health boards.

The front-line teams are in place at all times and will always be part of our immediate response to any new, evolving public health threat, as was the case with Covid-19. For the first few months of Covid, the public health teams in the boards were on the front line, providing the immediate advice and doing the management and contact tracing of early cases. The advantage of having strong, robust teams in local health boards is that they are very flexible. We turn our attention to all sorts of different public health threats and public health improvement projects. While we were able to turn ourselves fully to Covid when it was an emergency, those staff are not in any way wasted. It is a very efficient way to provide resource, because in times when we are not dealing with infectious disease, we are dealing with poverty, inequalities, cost of living, health issues, improving health services and so on.

On behalf of the directors of public health, I would like to make sure that we remember the importance of those teams and keep them in our sights. They are not big teams and they are not hugely expensive. In a typical health board, less than half of 1 per cent of the board's spend would be spent on front-line public health. I will give the situation in my board as an example. I am in a medium-sized health board and I am a director of public health. At the start of the pandemic, I had three and a half consultant colleagues and two nurses. That is the sort of size of team that we are talking about, but we were able to maintain a really strong and effective response against Covid for several months. It is important to remember that.

The Convener: That brings me on to my next question. The resource spending review indicated that the total pay bill will be held at 2022-23 levels, although we know that the pay levels will increase. At the moment, from the latest data that we have, the vacancy rate is 7.7 per cent for medical and dental consultants, and 8.7 per cent in nursing and midwifery. In addition, the sickness rate in the NHS overall is 5.7 per cent, when the target is 4 per cent. How feasible is it for the NHS and public health services to reduce staff?

Dr Foster: Partly, that is the wrong question. First, we need to remember that that might relate to staff costs, rather than staff numbers. I need to be careful not to give the impression that I am talking about something that I am not in fact talking about.

There are significant opportunities for us to increase efficiency and the skill mix of staff to achieve more for the money that we spend. If we consider a simple head count, it is unlikely that we will ever move to a situation in which fewer individuals are employed. Changes in working practices, flexible working, retirement policies and all sorts of other things militate against the actual head count coming down. We need to hang on to the specialists and the expertise that we have in the face of an ageing population and a large number of people moving towards retirement age. Those are all complex issues.

It is incredibly difficult to maintain staff numbers in the national health service at the moment. It is not a money issue; it is simply that there are not the specialist trained staff out there to do the jobs that we need. People use the term "fishing in the same pond"; we are all trying to recruit the same staff. Public health specialists, for example, are in great demand in Scotland, across the United Kingdom and internationally, and we find it really difficult to fill our posts. That is the same for every medical specialty. It is difficult to get surgeons or physicians, and it is difficult to find enough GPs and to get nurses. Indeed, our partners in the care sector are finding the same thing, too: it is very difficult to staff our care homes and our community care services. The whole of the health and social care system is under huge pressure, and it is proving very difficult to get enough staff.

Mary Morgan: Across NHS Scotland overall, around 3,200 additional staff were recruited and employed across NHS boards to undertake test and protect work. That does not include the number of people who were taken for administering vaccinations. That number has already reduced to 1,500, and staff are being redeployed, wherever possible, to the vacancies that you have spoken about. Much depends on what demand for Covid response will remain.

In NSS, we employed around 800 staff for the national contact centre to support the national work around contact tracing, to which Dr Foster referred. That number has now reduced to 260 staff through natural attrition, with people finding other employment or being redeployed. However, the demand for the service continues to support vaccination. As Dr Foster has said, we are very good at pivoting staff and services to deal with the new problems or challenges that present.

Staff who were working on contact tracing are now responding to and supporting the vaccination programme—they took 30,000 calls in the first week—to help Scotland's citizens to access it. We could cease that service if it is no longer required, but we need to see what this winter brings in terms of the demands that are placed on staff, and we need to understand what the future vaccination requirements and demands might be in order to get people vaccinated across Scotland, as well as what the digital solutions might be in order to reduce the number of staff that we have.

The position is quite complex, bearing in mind how work is done. A lot of it is inseparable from patient care: with much of the in-hospital care, people cannot just go to a computer and use Teams, although we have used digital means to reduce the burden on staff where possible.

Richard Robinson: I will start with the resource spending review, which is the starting point for staffing figures and prioritisation. Although the RSR is a good starting point for understanding what the priorities are, it is separate from the budget. It gives a sense of the challenges ahead and where they might lie. It is clear from the RSR that managing staff costs over the medium term is an important part of maintaining the trajectory of continued balanced budgets.

There is an acknowledgement within the RSR of a kind of trade-off between staff pay and staff numbers. It is partly a matter of understanding the data and the reasons for the increases over time. There are then the future plans. We have heard about redeployment; are those moves temporary or permanent? Are they front or back house? Some of those questions will probably matter in understanding how things could be managed.

The other point, which we have raised throughout the Covid-19 period but also before, is about financial sustainability. There were financial sustainability issues with the NHS position before we went into Covid-19, and those have not gone away. Within that, we need to reflect on the fact that there is a need for reform and a continuation of reform. There are NHS recovery plans in place, which we will be looking at as part of the next NHS overview work. We need to continue with that sense of reform, alongside controlling what the numbers may be in the future.

09:45

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. Before I come to my main question, I want to ask Mary Morgan a follow-up question on the answer that she gave in response to the convener.

I am interested in the numbers that you quoted regarding the reduction in staff in relation to the vaccination programme and contact tracing. Should we—perish the thought—have a new wave of Covid, or a new variant of Covid, as we go into the winter, how practical and realistic would it be for you to staff up again to the numbers that we have seen previously? Do you think that that is going to be necessary? If it is, can you do that without pulling people back out of NHS front-line services, given the tightness of the labour market elsewhere?

Mary Morgan: Whether that might be needed is perhaps a matter for public health colleagues. Our job is to be ready and prepared for that eventuality, and that aspect—thinking about what kind of surge we might need—is factored into our plans. For example, we are making sure that we maintain the training of staff in the contact centre, not only so that they can handle calls in relation to vaccination, but to maintain their contact tracing capability.

We have a number of flexes there. Not only are we retaining the employed staff—the 260 whole-time equivalents—who are employed directly through NSS; we are maintaining bank capability for those people who perhaps do not want to work with us regularly. We also retain contracts with third-party suppliers in order to give us that flex and to allow us to flex up.

One of the things that we learned through Covid was that, although the recruitment process was a monumental effort, we were able to do that really quickly and nimbly. In the event that we see another wave and we need to go through another preparedness plan, we have learning from the Covid experience that we could apply. It is not in our plans to have another start-out at the end of Covid. We are much more prepared than we were, and we have capability that has been built into play. We also have all the scripts that are available; we have all those kinds of things ready to step up. We are prepared for that.

Murdo Fraser: I put the same point to either of your public health colleagues, to see whether they have any comments on the impact on public health in the NHS, should the same thing occur.

Dr Foster: When Covid arrived, we did not have any of these big national structures—we had only our local front-line responses. Those small teams stood up and did as we have always trained them to do in the initial stages of dealing with a

pandemic. We have been very fortunate that all the national arrangements have been in place. There has been a huge recruitment effort, and we created test and protect, which did all the contact tracing and so on, supported by the local teams.

We are now gradually scaling that back and, by the end of September, pretty well all the staff who came in to do test and protect will no longer be with us. They have largely found other roles, so it has been a very positive experience. That has been very helpful.

We would expect to go back to the situation that we were in previously, in which we have local teams that are ready to respond. If we were to encounter a situation in which we faced either Covid or another infectious disease—we still have the same risk of a pandemic of influenza that we have always had, for example; those risks are still there—we would need to go through a process of scaling back up.

There is a special provision around Covid, which is that we have retained a small number of staff in what we call the VAM—variant and mutation—teams, who will be with us until the end of March to get us through the winter. The size of that staff group is not huge, but it is an efficient assessment of what we need to keep things going. That would enable us to get from where we are now, at a standing start, back up to scaling into a full response position if we needed it. We have that plan in place.

Again, to give a local example, that is four staff for a board the size of Forth Valley; it might be 20 staff for a board the size of Greater Glasgow and Clyde. I cannot remember the overall number for the whole of Scotland, but the numbers are of that order.

We have our local teams and we have some extra staff, but we have stood down the big national response because, frankly, we need to be efficient with the spend, and we will not get it back unless we absolutely need it.

The answer to the question about whether another pandemic is likely to happen is that nobody actually knows—we simply do not know—but that risk is with us all the time. We were ready for a new pandemic at the start of this, and we are probably significantly more ready now, so we have reasons to be relatively cheerful about our plans. We know that we can mobilise that national effort, which was a huge partnership that worked incredibly well, and which we should be proud of.

Dr Phin: I will come in on the potential likelihood of another flu pandemic. It is an unknown, but we can draw on previous flu pandemics, and they have been characterised by two or three waves of activity. Basically, a pandemic is when the whole population is non-immune and therefore susceptible. With each subsequent wave, more and more people become immune, therefore the sizes of the waves tend to reduce and the impact reduces.

We have the added bonus here of a vaccination programme, and many people have had three or four boosters. We know that vaccination will stop or mitigate severe disease and death, and hospitalisations, even with the differing variants. One of the vaccinations that is being used this autumn is what we call a bivalent vaccine; it has the original Wuhan virus, but it also has omicron, which is one of the more recent viruses.

Gradually, over a period of time as the virus evolves, it becomes more different; therefore being exposed six or seven months ago to an original variant might mean that you are still susceptible to a new variant, but you will get at least some protection. I do not think that we will see the measures that we saw back in 2020 and 2021, but the virus might have an impact, given that flu is a bit of an unknown this year.

My final point—to wind up—is that we have worked through what we call a variant and mutation plan, which is a plan for how we will respond to a new variant or mutation. We have described the new surveillance that we have put in place and how that links in. That should have been on our website this week, but it will be up next week. I am very happy to send a copy of that to the committee, for your information. It describes how we would work with health boards to identify and respond to a new variant.

Murdo Fraser: That is helpful, and leads me on neatly to the question that I was going to ask about public sector reform. The convener quoted from “Investing in Scotland’s Future: Resource Spending Review”, which is the background to all this. I will direct this question first to Richard Robinson from Audit Scotland—just so that you are aware, Richard; it is coming to you.

A couple of quotations from the RSR identify that there has been substantial growth in employment in the devolved public sector. The review states that

“continued growth of the public sector away from frontline services is not sustainable”.

It goes on to state that the Scottish Government recognises

“the need to reset the public sector following the COVID-19 pandemic, including by returning to a pre-pandemic size”.

From Audit Scotland’s perspective, how realistic is it to return the public sector to its pre-pandemic size? From a practical point of view, how quickly could that be done and what are the implications of that?

Richard Robinson: I will preface my answer by saying that my experience is more in public finances than in the specifics of the NHS audit.

However, there are two things to mention, one of which is speed and the other being the viability of returning the public sector to its pre-pandemic size. We in Audit Scotland have been clear throughout a number of reports that, as I mentioned earlier, to return to the way things were done before would end up with the same results, which would mean problems with financial sustainability.

Alongside that, we now know that there are, as well as a number of other pressures, additional pressures relating to inflation—which means that your money buys you less—that are not reflected in the RSR. The Auditor General has been clear that the issue is about actual reform and reconsideration of how services are delivered, with encouragement to deliver them in different ways and to think about the cost implications of that.

What does that mean for the speed at which it can be done? My colleagues on the panel will be able to say more about that. However, it would be reasonable to say that reform and changes in the ways in which things are done will take time—possibly several years. Again, that is where the medium-term financial strategy, how it continues to link to the budget and how the budget reflects it, will be important. It will be important not just for the coming budget, but for budgets over time, especially given the importance of staff costs as a lever that the Scottish Government is keen to use to maintain the balance between spending and funding.

As always, our point is that reform plans should be clear, costed and monitored closely through the budgets and, I say again, linked to the medium-term financial strategy to see whether they are causing difficulties and are on or off track, and whether action needs to be taken.

Murdo Fraser: Would any of our NHS colleagues like to come in?

Carolyn Low: Plans are in place to reduce all our Covid additionality over this financial year, so that by the time we get to the end of March, all additional spend will have been reduced and the workforce will have been redeployed. We would be left with the core elements around vaccination, surveillance—which Nick Phin mentioned—and managing and maintaining NSS's preparedness on personal protective equipment. That is the extent to which our Covid activity will be contained, as we move into future financial years.

The challenge that we have is about how quickly the additional capacity that was introduced to hospitals can be stepped back. In practice, it is currently being used to support recovery and to provide the additional capacity that is needed to address waiting times and so on. It has been argued that those factors represent moving out of the Covid funding area and into how recovery plans will be resourced going forward.

Mary Morgan: Thank you for your question, which is difficult and complex. My answer on the pace and magnitude of the reform that is needed is that it will be based on what society views as being acceptable and to be prioritised, against the reform.

In the health system, it is difficult to modernise or remove a service. As we have said, people want their services to be as close to home as possible. However, patient care that is better, and certainly more affordable, could sometimes be provided if we were able to do things differently. For example, does every hospital need to have an emergency department? Can we model elements of our elective care so that we can provide such services in different ways? Sometimes such approaches are not acceptable to society. However, the scale and pace of reform will depend on such views.

Dr Phin: Before the pandemic, in the respiratory diseases department in the new Public Health Scotland there were seven or eight people dealing with legionella, tuberculosis, flu, respiratory viruses and so on. During the pandemic, that number went up to just over 200 people so that we could meet the data demands and information requests that we were getting. Despite that, we had overtime bills of somewhere in the region of £1.5 million, because we simply could not get more staff to deal with that work.

We could do the work with those seven or eight people, but I am not saying that we would be able to deliver very much. It really comes back to what sort of public health response and service Scotland wants. Throughout the pandemic, we have tried to take advantage of new technologies, and we are automating processes, so we probably do not need as many people as we had at the peak—in fact, we have reduced the number. However, having worked in public health for nearly 40 years, in my view there is no question but that we will need more than we started with back in March 2020, so I cannot see us going back to those levels.

However, clearly, there are opportunities. Our organisation is undergoing restructuring to enable us to focus on our new priorities and to do whatever we can to be as efficient and effective as possible. There will be reductions, but if we were asked to go back to six or eight people we would not be able to deliver what I would consider to be an adequate service.

Murdo Fraser: Thank you. That is very interesting.

10:00

Alex Rowley (Mid Scotland and Fife) (Lab): The question whether every hospital needs an emergency department is, perhaps, a theoretical one. Most people would think to themselves that emergency departments are struggling to cope as it is. People are being left in ambulances that are sitting outside emergency departments for hours, and hospitals seem to be completely run off their feet and struggling to cope. That seems to be the reality of the situation.

My question is whether the current year's budget is adequate to get us through and to meet any challenges that might come. Audit Scotland said:

> "Public services faced financial pressures before the pandemic. Covid-19 funding was used to ensure the financial sustainability of councils and other public bodies. But now Covid-19 specific funding from the UK Government has ended, pre-existing pressures must be balanced alongside continuing spending demands related to the Covid-19 response and recovery."

Is the budget adequate to do that? One part of the recovery is that we have massive waiting times, like nothing we have ever seen in my lifetime. People are waiting for hip and other replacements. That, to me, needs recovery. Although Audit Scotland points out that public services faced massive financial pressures before the pandemic, those pressures must now be much greater. Is the budget for the NHS in Scotland adequate to fund recovery of those services?

Mary Morgan: I will defer to Carolyn Low. I cannot speak to the overarching budget for NHS Scotland. That is for the Scottish Government to answer on. Carolyn might be able to give some insight.

Carolyn Low: The challenge is that our overall resources are finite. We therefore need to ensure that we are managing within those financial limits. That challenge is not restricted to healthcare: it is faced by all parts of the public sector.

The NHS has been given additional budget resources this year. The money that we had to respond to Covid during the pandemic was, in practice, unlimited. It felt as if we were properly resourced to do what we had to do. We were able to make a phenomenal response on behalf of the country. The reality is that that spending resource has ended. We now need to get back to a more sustainable position and must deal with wider pressures from inflation.

Real choices must be made within health regarding prioritisation and what we should spend our money on. Our choices are clearly limited, as we face the scenario that you described. There are real pressures on our hospitals and we must tackle them: we have no option but to do that. We are actively and collaboratively working with Scottish Government health colleagues, particularly with finance teams, to identify opportunities to reduce costs and redirect resources.

That is a challenge, and it would be wrong of me to say that we will be able to do it comfortably. There will have to be discussions about prioritisation. Those discussions are being actively pursued at the moment.

Alex Rowley: With that in mind, and within current budgets, is your organisation in a position to deal with potential winter spikes in Covid, flu and goodness knows what else, or is the expectation that you would need emergency funding to deal with major spikes in any of those areas?

Carolyn Low: The test and protect resource element of the Covid funds is managed separately, at Government level. My understanding is that what is needed will be made available to be spent on dealing with any peaks in the winter. However, we are actively trying to reduce that cost, to work as effectively as possible and to make our response as efficient as possible, so that we manage that resource.

For our wider Covid spend, we started the year with a forecast at the end of March of what we thought we needed. We have been funded to 65 per cent of that. We are actively managing and prioritising our response; from the NSS perspective, we believe that we will be able to do it. We have been able to manage and prioritise our resource and we are comfortable that the elements of our response should be manageable within the funding envelope that we have been given.

There has been a lot of work and it has involved making, to some extent, a lot of difficult choices to get us to that position. However, we need to be realistic. Unfortunately, resources are no longer infinite, as far as the Covid response is concerned, so we need to prioritise our efforts and resources for the aspects of our response that will make the biggest impact. That is about prioritising vaccination and surveillance activity, as well as making sure of our preparedness.

Alex Rowley: Does anyone else want to comment on that point on the budget that has been set? If there are any major spikes, will we need emergency funding? Yesterday, we heard the statement from the Deputy First Minister about the overall budget and the cuts that are having to be made in order to fund pressures. If there are any other major spikes in health issues over the

coming months, will we need emergency funding to be made available?

Dr Phin: I can speak only for Public Health Scotland. We have had discussions with the Scottish Government and have been given funding for 2022-23 in relation to the vaccination programme, surveillance, and the small team that we will be using to investigate variants and mutations. We are therefore actively recruiting to and filling the posts that we need. From that perspective, we are reasonably comfortable. Obviously, we are not involved in the acute direct response, but we will be giving an early indication of whether the vaccine is working, whether a surge is likely and what the impact might be. We are helping to prepare, if you like.

Alex Rowley: Finally and quickly, I will ask Mary Morgan a question about her comments about the labs having been ramped up. You said that there is a balance to be struck in respect of whether you will require on-going funding to operate the labs at an underutilised level in order to maintain them. Are those labs not still under a lot of pressure? I see that you are indicating that they are not.

Mary Morgan: Initially, we participated in a UK testing strategy with the Lighthouse laboratories. People saw all the efforts that were made on that. We utilised hospitals' existing laboratory testing capacity and built three regional Covid testing laboratories, which are kitted out to manage many thousands of samples. That number of samples is not going through them now. Hospital-based polymerase chain reaction testing has reduced, and there was a rise in the use of lateral flow devices—the test that people do in their own homes.

The PCR requirements have reduced considerably as the testing strategy has come down. The regional labs are ready. A large number of biomedical scientists were recruited for them. As a job family, that is also difficult to recruit to—we have blood transfusion labs and it is difficult to recruit biomedical scientists to them and their staff have been redeployed.

Pending a wider strategy and what happens after the winter, we are maintaining those laboratories in a state of readiness. There are many regulatory requirements around them. There are servicing and maintenance costs for the equipment in them, and there are—not least—the cost of consumables that they go through. The laboratories exist. They are in premises and meet the regulatory requirements to function as annexes where they are held, but they are not fully staffed just now. In fact, I visited one only a couple of weeks ago and no activity was going through it.

John Mason (Glasgow Shettleston) (SNP): My big question is about how much money we put into being ready for next time. Yesterday, we had £500 million of cuts or savings. Across Scotland, there is huge pressure on resources. How do we get the balance right? Mr Rowley was asking about that and it is where I would like to start. Even in an empty lab, there must be a bit of a cost. Perhaps you have to keep a bit of heating on and I presume that the equipment gets out of date after a few years.

Perhaps more obviously, the NHS National Services Scotland submission mentions PPE. I do not know how long a rubber glove lasts, but I think that it has some kind of end date. Correct me if I am wrong, but we could spend a lot of money on rubber gloves and then have to throw them all out after three years. At the beginning of the pandemic, there was a bit of a concern. Some doctors said that they had been given PPE that was out of date even though it might have been okay.

I am struggling a bit to know how we get the balance right. I will come to the witness from Audit Scotland in a minute to see whether there is a mathematical answer to the question, but do you have any thoughts, Ms Morgan?

Mary Morgan: I do not think that anybody can say what is the right size of stock for the future, although we can do some planning and make things different. We have addressed some of the storage capacity.

PPE is a good example to focus on. In Scotland, we had a separate pandemic stockpile that sat in a warehouse waiting for a pandemic to come along. It did not have stock turnover. Through the pandemic, we have realised that we really need to use our existing stock. Staff need to know and understand how to use it and we need to get turnover from it.

We now hold more in stock but always have turnover. The learning for us is about how we leverage our single national procurement in the NHS to service more of the public sector. We need to have turnover and make best use of our stock so that it does not expire, so that we keep abreast of what is modern and what staff need to use by way of PPE, and so that staff are fully trained in its use and how we distribute it to people.

Another thing that we need to bear in mind and one great thing that has happened through Covid is that we have a really good local supply chain for PPE. Manufacturers came forward in Scotland and helped Scotland to get its PPE. We need to put through minimum orders to maintain that provision and those jobs in Scotland, so that supply chain piece needs to keep coming through.

That is a different model. We do not hold a separate stockpile of PPE in a warehouse somewhere down the road. We want to make that part of how we operate day to day. Having those supply chains in place and learning from what we did means that we can flex up and down as necessary. However, volume is critical to us.

John Mason: That is very helpful indeed.

Mr Robinson, does Audit Scotland have a view on such things? Can you say, for example, that there is a 2 per cent chance of a pandemic in any given year and, therefore, it is worth putting a certain amount of money into PPE stock? That sounds like a sensible answer to me, but there is a cost to keeping more stock in storage instead of having a just-in-time approach so that it turns up on the day that you need it. Would Audit Scotland have a view on that?

10:15

Richard Robinson: We would not look at the specifics of the percentages of chance. Our colleagues would be much better placed to carry out that work. However, that emphasises the point around the data that would inform the likelihood of scenarios and—as was discussed by Ms Morgan—the learning from the past pandemic in relation to methods and where there are efficiencies and moneys.

As we have said, managing a budget in a period of extreme and significant uncertainty and volatility is hard. We said that before the pandemic as well as during it. There are lots of unknowns, and it is useful when data can be used to bring a little bit of shape to those, in order to be able to understand where the budget would be able to flex.

The balance between short-term pressure and the longer-term objectives and outcomes that the Scottish Government is looking for is a perennial question. We see that in the strategic framework, which contains a number of shorter-term and often more quantifiable elements, such as in relation to vaccinations, PPE and surveillance. However, the strategic framework is also about addressing and recovering from the longer-term effects of Covid-19, such as in relation to mental health and health inequalities. The balance between those will change over time depending on the nature of the circumstances. It is about maintaining oversight and asking whether we are delivering against the overall shape of the strategic framework, including supporting the longer-term objectives.

In relation to budgeting spikes, as is reflected in the work that we have done around public finances and in our Covid-19 finances report, what the rest of the UK does also matters. If a spike is reflected in the rest of the UK and results in additional spending in an area, there may or may not be Barnett consequentials in that area. The issue is also about reflecting the way that Barnett consequentials work their way through to the Scottish budget and make a difference. In a way, if the problem is with a spike or new variant at a UK level, that might be different from there being divergence because of something specific to areas of Scotland that is not felt or responded to in the same way by the UK.

John Mason: Even if England built up a huge store of PPE and we got a share of the money, we would not be bound to spend the money on the same thing.

Richard Robinson: You are not bound to spend Barnett consequentials on anything. They are not necessarily linked to where they have come from. There may be some conventions, but that is not the nature of things. There are examples with PPE and Barnett consequentials where different arrangements and spending differently meant that less was spent to get the same result. In the quote that was read out earlier, we were saying that the specific Covid-19 Barnett consequentials guarantee is not there anymore. However, the budget process and the funding process will still work in the same way as they have in other years.

John Mason: Dr Foster, we have the national picture and the health board picture. Obviously, health boards are under pressure financially. How are they thinking about the long term? Are they keeping a bit more in reserve or ready for the next pandemic, as opposed to thinking, “Let’s fix hip replacements tomorrow”?

Dr Foster: You are absolutely right that NHS health boards are under exceptional pressure. It feels like that and it feels like that to our staff—everyone is working really hard. I have something useful to add to that discussion. We have been talking about the capacity of the NHS, the budget that we have and trying to deliver front-line services. That boils down to the efficiency of the system and how we run it. It is unlikely that we will get a vast amount more resource from the public sector to provide health services, so the way to provide better front-line services is to be more efficient.

It is important to reflect on how we run health services. There is a sort of wisdom—which others are more qualified to talk about than I am—that the most efficient way to run a health service is at about 85 per cent bed occupancy and 85 per cent efficiency. I am sure that the committee will have heard that sort of suggestion before. In Scotland, we have been in the habit of trying to run our NHS at 95 to 98 per cent efficiency, with all our beds full all the time and using every single available pound as efficiently as we can.

In a normal situation, that is very efficient, but it means that, when things get bad, we have no reserve, resilience or ability to bring in extra patients. We do not tend to have mothballed wards or hospitals that we can bring on to deal with the extra peaks. That is the nature of being a very efficient system. At the moment, it almost feels like we are running at 120 per cent efficiency, because the reality of the situation is that we have more patients for hospital beds than we have beds to put them in, which is quite challenging.

I can see only two ways forward to fix that. One is that we commit to having more capacity, which relates to your question about whether more budget would help. At the moment, in the short term, more budget probably would not help, because we cannot get more staff or build more buildings in the time that we need to do so in order to get through this winter. Therefore, the only way that is left to us is related to efficiency.

My thoughts about efficiency relate back to an earlier question about how much of our activity is in front-line services. There is learning to be had from the pandemic. Particularly in the first year, we shut down a lot of our back office functions, we had a lot fewer meetings and boards, we had less governance and we devoted our entire effort to the front door. During that time, we were a lot more efficient, so there is a question to be asked about whether there is learning from that and whether we could be more efficient in the NHS by spending less time in front of computers and at committee meetings and more time with our patients. I think that there is an avenue to be explored there.

John Mason: Fewer meetings and less time in front of the computer is quite an exciting proposal for politicians.

Dr Foster: Would we not all like that?

John Mason: Dr Phin, I do not know whether you have anything to say on that, but you also mentioned vaccinations. Are we talking about one vaccination per year for Covid—just the same as for flu—or do we not know that yet? Could it be two a year? Would two a year make a big difference to the cost?

Dr Phin: We do not know that yet. The hope is that, if we get through the pandemic at some point in the near future, we might not need that vaccination. However, at the very least, we are probably looking at an annual booster. Yes, if we give two boosters, there will be a cost. The cost of administering vaccines is not just about buying the vaccines; it is also about storing and distributing them and getting staff to put them into arms. There is cost associated with that.

The third element, which I passionately believe in, is prevention. The impact that Covid had in the most deprived communities was clearly demonstrated. There were higher numbers of deaths, hospitalisations and severe disease. Therefore, tackling deprivation has to be an underlying priority. We are not going to stop people dying, but we can ensure that their lives are as long, fulfilled and disease free as possible, so that their use of the healthcare service is minimal. Although that does not address the immediate problems, at some stage, we have to start investment in the prevention field, in order to ensure that our population is as healthy as possible, because that will have the biggest impact.

One of my concerns is that, in 2020, when we looked at obesity or overweight in five-year-olds, there had been a 25 per cent increase in the number of children aged five who were considered overweight and obese. If we do not do anything about that, that cohort will go right through to become 35-year-olds and 45-year-olds who are obese and at risk. I suspect that, if we look at 2021, we will see a very similar picture. We have evidence of the impact on our children and we need to focus on trying to address that, otherwise we will worsen the problem at some point in the future.

John Mason: I presume that the cohort of people who are obese are the same people, especially when they get older, who would be at risk from Covid or a similar pandemic.

Dr Phin: Obesity is associated with an increased risk of cancer, diabetes and high blood pressure—a whole series of things that lead to premature death and disability. It is the disability that has the biggest impact on the health service, because of the need for healthcare. At the moment, we need to focus on prevention and address those groups, because tackling some of those inequalities would be a good investment for the future.

John Mason: I go back to the submission from NHS National Services Scotland. I was intrigued by something on page 5 of your paper, Ms Low. The third paragraph on that page mentions the national contact centre. It says:

> "The stability and expertise offered by the NCC will be key in delivering strong vaccine uptake rates. Alternative solutions which prima facie offer a more cost-effective approach to vaccine delivery could undermine the Strategic Framework through reduced or delayed vaccine uptake."

I was not quite sure what that meant. What are the "alternative solutions"?

Carolyn Low: What we are trying to say there is that the most effective way would be to have a digital-first channel, which would encourage people to book online to get their slots for vaccination. That would all be supported through digital-first means. There would be a cost to

setting that up and maintaining it, but we would not then need to spend money on letters, which give rise to additional costs. There was a significant amount of expenditure during the first few waves of the vaccination campaigns, which involved lettering people. We all remember the blue envelopes. A significant cost is attached to that. If we moved to a digital channel, we would remove all that, but we would then possibly exclude the most vulnerable people in our society, who are excluded digitally.

The national contact centre provides a channel for people to be given advice. It takes pressure off local public health teams, which do not necessarily have to deal with the sort of questioning that comes in. We are offering that channel: an efficient front door, which provides support and which is a very useful adjunct to the digital-first channel. We have to recognise digital inclusion and the connection that it brings to the most vulnerable and at-risk people. We want to ensure the take-up of vaccination across the population.

John Mason: Thanks. We could pursue that further, but I think that I have used my time.

Brian Whittle (South Scotland) (Con): Good morning. Dr Phin, you have opened a whole Pandora's box regarding my specialist subject of prevention—we could probably take up our whole time on that. However, I want to return to your point that vaccination is a key element of Covid recovery. We are currently vaccinating over-50s again. This is anecdotal but, judging from those whom I have been speaking to, there seems to be a higher number of people deciding not to take the next vaccination than was previously the case.

Referring to your point that we require the level of vaccination to stay high to prevent Covid in future, how do we keep the rates high, and how do we keep the public informed? How do we maintain the importance of vaccination?

Dr Phin: One area that we should focus on more is public engagement and communications. We should try to help people to understand the benefits of the vaccine and the potential risk.

The plan is to do that through a variety of means. The first is to provide statistics, to give people an indication of what is happening in their area and, we hope, allow them to make a decision. If prevalence is high, that might prompt people to get vaccinated. Secondly, on communications, we are working with NHS Inform, which is the main route for communication with the public. We are taking every opportunity that we can to keep pressing the point that the vaccine offers protection.

It is becoming clear that protection from the vaccine can be long lasting. We rely on two facets. First, we rely on a high antibody level to stop the virus attaching itself in the body. Secondly, we have cell-mediated immunity from the white blood cells that will remember and therefore fight the virus. The cell-mediated immunity has a much longer duration. The antibody level peaks, then drops after three or four months, which is why a lot of people get milder symptoms without necessarily going on to develop the very severe disease.

10:30

Our understanding of the benefits is still evolving. The larger part of the population will already have been vaccinated. The focus is therefore on trying to boost the immune systems of those people who are more at risk. One thing that we know with Covid is that age is a key factor in determining risk. The older someone is, the more likely they are to have severe disease and to suffer its effects. It is about targeting and trying to use our resource in the most effective way.

Brian Whittle: I go back to what the convener started with: the pressures on the NHS workforce. We were given statistics on vacancy rates, but those are averages across the country. One benefit of being a list MSP is that I work across a number of NHS boards, and it is obvious that the statistics vary greatly across boards. In South Lanarkshire, it is extremely difficult to get an appointment with or even to speak to a GP, yet, in South Ayrshire, it is easier to do that; however, the neonatal units in South Ayrshire are under extraordinary pressure, whereas those elsewhere are perhaps not.

Linking to that, I was looking at numbers of excess deaths over the period of the pandemic. Deaths due to cancer, dementia, circulatory issues and respiratory issues were significantly fewer than expected during the Covid period. We can read into that what we will. Obviously, we need to understand that, in measuring Covid, it was important to be consistent, so that we could identify trends.

Looking at the budget, which is coming increasingly under strain, how do we take all those factors into account in the management of an NHS that will change? Perhaps Mary Morgan would start with that easy question.

Mary Morgan: There is an awful lot in there about the public health aspects of how one changes a system. Resources are finite.

First, in relation to staffing and workforce across the NHS, the two areas are recruitment and retention. A number of actions and activities are in place to help to retain our staff and ensure that they feel valued, and to continue with recruitment. The committee may like to take evidence specifically from human resources professionals,

who are not in the room today, given that that area is a big part of the spend.

I work for National Services Scotland, and I do not represent the NHS in Scotland, so it is difficult to respond to comments about experiences across the country. However, resources are finite, and we have choices about our priorities and spending. With Scottish Government colleagues, and collectively—through our national and regional planning processes, and the local processes that are in play—we continue to make plans for spending our money, and priorities are contributed to and influenced by us.

I am struggling a little to give you a definitive answer on the health and social care system across Scotland. We have money, and we need to think about how that is deployed. It seems to me that, in tertiary services, there is sometimes a tension between a local community partnership or community priority and priorities elsewhere. The issue is complex and probably needs broader consideration than I or colleagues can give in this space.

Brian Whittle: I should probably declare an interest: my daughter is a medic in a neonatal unit. I knew how complicated the question was. My point is that priorities shifted drastically during Covid, out of necessity. That has left a major issue that we must deal with at some point. When there is pressure on NHS budgets—as there is—how will all that be considered? Carolyn, do you want to have a go at that?

Carolyn Low: Finance professionals in health need to work closely with Government colleagues. We have a problem understanding the difference between local needs and pressures and the way that the funding is distributed in the first place.

We get a formula allocation that reflects population and deprivation. There is a formula called NRAC—the NHS Scotland resource allocation committee formula—that allows funds to be distributed equitably to health boards. That is the income, but there are different local pressures. We must ensure that we fully understand those and are able to decide whether we should do something different about that distribution. That is a system-wide challenge that is easy to talk about but difficult to put into practice.

The other aspect of our funding comes from policy priorities. We get ring-fenced resources that are distributed for particular purposes, such as mental health or tackling drug deaths. When there are areas of real concern across the country, resources are usually made available for those.

The challenge that we have is that local dynamics are different. When aspects of the budget are devolved to local integration joint boards, you get different priorities in different areas. That is arguably right, because it is important to tackle local concerns and put resources where they can have the biggest impact, but when you look at what that means overall there can be a disconnect. That is why there can be a disparity of service in different parts of the country.

It is a really complex issue. It is important to understand the pressures and think about how we can deliver services in different ways to allow for a more equitable distribution of services across the country. We need to focus our reform agenda on a longer-term view of what health and care look like and how those services will be delivered in future.

At the moment, we are reacting to real local pressures—all the thinking and effort are about tackling day-to-day issues. We need an opportunity to draw breath, stand back and think about what to do for the future and about our longer-term vision for health and care in Scotland. That is the difference.

In doing that, it is important that we reflect on some of the positive legacy of Covid. The way that the system came together and worked together was amazing. There are often challenges and conflict when different organisations meet. If you talk to people about their experiences in accessing care from different entities, they will say that that is a frustration. That was largely resolved by the way that we worked on the pandemic response. We were all in it together; it was a national response. We should learn from that to make sure that we work seamlessly.

We have also introduced a huge amount of digital technology and capability at pace. It is really important that we do not forget about that but reuse that capability in different ways to enhance our services.

There is lots of opportunity. The challenge is that it is very difficult at the moment, with the pressures that the system faces, to take a step back and think about what the future holds.

Brian Whittle: Thank you—that is really interesting. I am a big advocate of increasing the adoption of technology in healthcare. It is a major way in which we could make a step forward.

I will push that point a little bit with you, Dr Foster. I was trying to highlight the point that one impact of Covid is on non-Covid-related conditions. Understandably, we had to focus hard on Covid and the public expected that to happen. Ms Morgan talked about what is acceptable to the public. I imagine that there has now started to be a shift back towards elective surgery and cancer care, for example.

On Ms Low's point about the adoption of technology, how realistic is it in the current

situation to talk about giving the health service space to breathe and to consider the long-term strategy for what healthcare will be like in future?

Dr Foster: I will be brief, because I am aware of time.

One thing ties together all the questions that you asked: the importance of behavioural science in understanding what motivates people. Many of our problems are about being able to recruit and retain staff, encouraging the public to take up vaccination and people understanding how to engage with health services and what is efficient. Why are we not coming out of the pandemic with a population that would be proud to move into care services, such as nursing and doctoring? We have an opportunity to reflect on the pandemic and step forward positively out of it.

It is important to stress that we have not stopped all the elective care. A massive amount of elective care is going on. It is really difficult just now, because we are under huge pressure, but we are making progress. Elective care centres are coming online and things will step back up, but the critical factor is that we need the staff to do the elective care.

We need to understand how we can create a situation in which people are still proud to work in and want to work in, stay in and contribute to the care services and care professions. That is how we will get out of the situation. We just need the people. The NHS and the care services are all people businesses. They are all about people and, if people do not want to be part of them, that is a real challenge.

There is a positive future and we can get to it, but it is all about recruiting and retaining staff and making people proud to work in public service.

The Convener: We are slightly off topic. The Health, Social Care and Sport Committee is considering NHS reform, and we are more focused on the Covid recovery strategy.

Brian, do you want to ask another question before we move on?

Brian Whittle: Unless anyone else wants to answer my question, I am happy to leave it there.

Dr Phin: In Covid recovery, we should not forget the people with long Covid. The Office for National Statistics has estimated that there are about 200,000 people in Scotland with long Covid, which presents in variable ways, such as depression, mental health issues, suicidal ideation, lethargy and listlessness. There is a whole series of presentations. That is part of our legacy. We should not forget about those people. It is a substantial proportion of the population.

The Convener: Absolutely—that is a valid point.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): You clearly read my mind, Dr Phin, because that is exactly what I was going to ask about.

One problem with being the last speaker is that many wee questions have sprung up over the course of the meeting. I will try to rattle through them quickly. The witnesses might have answered some of them.

The first thing that came into my head was the cost of funding the response to the pandemic in the first place. I have never done budget scrutiny before. Where did that budget come from? Carolyn Low said that an unending amount of money was available to deal with the pandemic. We now need to ensure that we get vaccine uptake and deal with long Covid—I will come on to that in a minute—and there are a load of other costs. Are they being absorbed by the original NHS budget or is there extra funding over and above that to deal with the extra challenges that are coming out of Covid, despite the fact that we might not be out of it?

Carolyn Low: There is no additional specific Covid line. That stopped at the end of March last year. However, expenditure consequentials—for vaccination, for example—will continue to flow. Elements of the pandemic response will have to be maintained on a recurring basis, and we should see elements of Barnett consequentials flowing into that. The extent to which that will be the case is not yet clear. We need another budget settlement to see where that lands.

10:45

Jim Fairlie: I will stop you there, as that brings me back to something that Richard Robinson talked about earlier. The point about Barnett consequentials interests me. If Scotland has a specific healthcare issue, whatever it is—for instance, it could be a virus that is present in Scotland but not in the rest of the UK—how does the Scottish Government fund the response?

Carolyn Low: It would have to be funded from within our resource.

Jim Fairlie: So it would be from Scottish resource.

Carolyn Low: Yes.

Jim Fairlie: Okay—that answers that question. That led on well—you guys are good.

I have a couple of other wee bits and pieces to raise—please bear with me. Alex Rowley asked a question about the budget for getting people into the service. Is it a financial factor that is causing the problem? Is it to do with having enough people in place or is the issue that people are not

available to do the job, that they do not want to do it or that they have moved away from it? There has been a huge churn in people's lives. People have decided that they do not want a life working in hospitality any more, for example. Is the same thing happening in the NHS? Is one of the resourcing problems that you have to do with staff, rather than it being a financial problem?

That question is for both of you—please crack on.

Mary Morgan: The answer to that question is hugely complex. As Dr Foster said, there will be some behavioural activity involved. The two years of Covid have exhausted our staff—both those on the very front line and those people whom Dr Foster referred to as back office support. A lot of the digital and IT work that went on behind the scenes has taken its toll in that space. There is no doubt that people are tired. They are reframing not their work-life balance but their life-work balance, and they are considering where they want to work. A number of people have resigned from their roles because they want to move closer to family. In some ways, family has become more important to some people.

The situation is multifaceted and multifactorial. Colleagues in NHS Education for Scotland and the Scottish Government will be able to say more about the analysis of that.

There are other factors at play, too, such as the implications of pension taxation on whether people can afford to retire and the age at which they can do so. A policy has been introduced recently whereby people can retire and return to the health service, which helps to ensure that there is skills retention. The vacancies that the convener referred to earlier are in the world of nurses and doctors, but there are other job families where the market is strong, such as those of biomedical scientists and digital roles, and the public sector cannot compete with the private sector in some of those areas of work. That area of the recruitment and retention of staff across the health system is hugely complex.

Dr Foster: First, I will pick up on the back office thing. I want to be absolutely clear about this: I do not think that the NHS has too many back office staff, just in case anyone thinks that that is what I said. I absolutely do not mean that. I think that we spend far too much time on back office-type functions. We sit on governance committees, audit committees and performance and resources committees, and we hold board meetings. We need to reflect on whether we really need to do all that stuff to that level and depth.

Is it necessary for us to have 32 integration joint boards, 14 health boards, 33 community planning partnerships, 33 community justice partnerships and 33 alcohol and drug partnerships? As a director of public health, I could sit on all of them. Many of those groups have between 500 and 1,000 pages of print for each meeting. It is an extraordinary industry of bureaucracy, and I am supposed to be a front-line doctor serving patients in the NHS. At those meetings, I am sitting alongside increasing numbers of senior doctors and nurses who are servicing the meetings. We do not have lots of managers and administrators to do that. People think that we do, but we do not—we are actually quite light on that.

The back office stuff that we do is right, as we need governance, accountability and everything else, but we perhaps need to take a breath and consider whether we need quite so much of it. That would be an area of saving. For me to be freed up, I need more people to ensure, for instance, that the pay and rations gets done. It seems crazy to me that, as a director of public health, I fill in people's pay and rations stuff as part of my role. That seems bizarre. It is not what I spent 30 years training to do. However, in our current system, that is the way that we run things, because we do not have people to do that for us any more.

Moving on to the actual question, I note that there are two big issues. The question was about whether more money would help. Right now, the core of the problem is not that we are not working flat out, but that demand is exceeding supply, not just in the health service but in the whole care sector as well.

A huge problem for us is that the care sector is really struggling with huge numbers of vacancies, so older, frail people in hospital have nowhere to go. Staff in hospitals are looking after lots of older, frail people who do not need hospital treatment but need care. It is really difficult to get them back into the community because the services are just not there. There are no people to do home care visits or to staff care homes. That is a real challenge. It might be partly about money in that sector. It could be argued that paying more would get more people in. Equally, however, such people might just be sucked out of other areas of the health and social care sector. The issue therefore involves something about the absolute number of staff.

When it comes to the recovery, we do not have any operating theatres that are standing empty and not being used. They are being used every day, flat out, to try to catch up. In that respect, I am not sure that we could do a great deal more. We are just behind. We are running as fast as we can with the available resource, but the resource is people, buildings, operating theatres and so on, and not just money, so there is no quick fix. Is that enough of an answer?

Jim Fairlie: I will press you a wee bit because of something that Mary Morgan said earlier. John Mason talked about the just-in-time supply chain and you talked about 85 per cent being the most efficient bed occupancy rate. How much financial value should be placed on the ability to have a continuity of supply—a resilient supply chain—in order to keep a critical mass? Is there a financial value in having the critical mass that you talked about? That question could also apply to bed occupancy. Do you understand what I mean?

Dr Foster: Yes, I think so. The challenge is that we have driven ourselves to be ever more efficient, and then an extra thing has come along and overloaded the system. It is really hard to reset that system.

I am very attracted to the idea that we all just need to take a breath and start again. However, we do not get to do that, of course, because of the demand. The queues are still outside accident and emergency departments as we speak. We therefore do not have that ability. However, at some point, we need to stop and reflect on what we are doing. Part of the issue is that we need to find some things that we perhaps do not need to do as much, could stop doing or could do differently.

Jim Fairlie: Okay.

Dr Foster: I am sorry. It is not an easy one.

Jim Fairlie: I am sorry to go off at a tangent, but John Mason said something about the value of having a stockpile. There is a purely financial value, but there is also a value from a qualitative point of view in being able to deliver the system at the time at which it is needed. Do you see what I mean?

Mary Morgan: It is about throughput.

Carolyn Low: It is. The key is that we can have a bigger stockpile if there is a greater value of turnover, because in that case we can justify holding that stockpile and making that initial investment.

We desperately need everybody who needs to use PPE—not just in the acute sector, which we supplied pre-pandemic, but in social care and perhaps other parts of the public sector—to draw their supplies from us rather than buying from other sources, so that there is a single supply chain for that product. That allows us to maintain a stockpile at the maximum capacity and get the turnover so that there is no wastage in the stock. The last thing that we want is to buy gloves and masks that then go out of date—

Jim Fairlie: Yes, or to have 10 suppliers coming in with different methods of production and what have you. If some of them dropped off, you would lose that critical mass when you needed it most.

Carolyn Low: During the pandemic, we had a global supply chain that was supplying China. The whole world was trying to source PPE from the same manufacturing plants. They were running full time and countries were buying the entire production of a plant at one time. There were jumbo jets full of PPE. We want to get away from that scenario and have a local supply chain so that we have secured that supply for when we need it.

Jim Fairlie: That local supply chain is now up and running, and there is huge value for us as a country in ensuring that we keep it functioning.

Carolyn Low: In a scenario where we have to ramp up, rather than paying a manufacturer in China to do that, we are paying locally-based Scottish manufacturers.

Jim Fairlie: We are paying someone here in Scotland.

Carolyn Low: That has huge economic benefit.

Jim Fairlie: Mary, do you want to add anything?

Mary Morgan: I thought that you were asking how that applies to bed capacity. When in-patients are in hospital in acute care, those acute beds are more expensive than having the same patients cared for in a more homely setting in a care home. There is a cycle of where we hold our bed stock, what is needed for throughput and how we reduce length of stay. It is very complex.

Jim Fairlie: I really do not envy you guys the job that you do in trying to juggle all of that while not knowing what is coming down the road.

Dr Phin, I want to ask about recovery from long Covid, which we talked about immediately before you came in. Is there a budget to deal with research and treatment? Every one of us has constituents coming to us who are suffering from long Covid, and the message that we are getting is that not enough is being done and there is not enough help. Is there enough budget and is there research into how to deal with long Covid?

Dr Phin: I cannot comment on any global budget, but Public Health Scotland is working with the University of Glasgow. We have a project that is looking at people who present with long Covid symptoms. It is not just about the self-reporting of symptoms, which is what the ONS bases its statistics on. Our study is on-going and a paper is due to be published in the next week or so. I will be happy to provide that to the committee.

The study is trying to understand whether we are dealing with one thing or, actually, with multiple things that require different interventions. Until we understand that, it is difficult to do anything more than provide supportive care. The study is about trying to understand the condition. We are involved in looking at that, but we probably

need to tie in to some of the work that is being done at the UK level in order to get access to the numbers that we might need to understand the answers to those questions, and also to share expertise and knowledge. The greater the number of people who look at an issue or a problem, the more likely it is that they will come up with a solution. We are doing some primary research, but we are also trying to link in to other research that is being done elsewhere.

I am afraid that I cannot talk about funding for services. That is not an area that I feel I can comment on.

Mary Morgan: A long Covid strategic network has been established through the national services division, which is part of NSS. I cannot remember the exact amount, but funds have been distributed through that network to allow health boards to set up services that respond locally to people's needs. That is not a recurring sum of money—it will not go on for a long time. Long Covid is emergent and we need a better understanding of what is needed, but funds have been distributed to assist people who are experiencing the effects of long Covid.

Jim Fairlie: You are saying that we need to find out what we need to do before we can budget for that.

Dr Phin: We need to understand what we mean by long Covid. Twenty-five years ago, we talked about autism as if the same syndrome affects everyone, but it does not. We understand that now. We need to get an understanding of long Covid. The pandemic has been going on for two and a half years now and we have been looking at long Covid for only two years, which, for a chronic condition, is not very long. I know that it is difficult, but we need time to look at it.

11:00

The Convener: We have just enough time for a very brief question from Brian Whittle.

Brian Whittle: One area that we need to touch on is the level of funding that the Scottish Government should allocate to future pandemic preparedness and long-term resilience. Obviously, inflation and supply chain issues are currently putting pressure on that. Pre-pandemic, through exercise Silver Swan, we knew that the biggest threat to our public health was likely to be some kind of global pandemic, yet we allowed that work to slide. How do we maintain that preparedness? How robust do we need to be in order to make sure that our preparedness is kept at that level? I put that question to Dr Foster.

Dr Foster: The important thing is that we need robust, resilient NHS services that can respond to anything. We also need to be efficient about how we plan. As we have discussed, it is not efficient to take a large chunk of money, use it to put a million masks in a warehouse somewhere and think that that has ticked the preparedness box. That is not a good way to behave.

We need to design our systems so that they have a little bit of resilience in them in order that we can respond when we hit rough water. Ultimately, we can deal with any emergency if we can get through the first little phase, because the public services will kick in and we will respond. We must not get to a situation where our services are so thin that we cannot mount that initial response. It is about who holds back and who puts their finger in the dyke for the first few months while we all realise what is going on. Once the evidence comes and we understand the disease, we learn what is required and we make the big decisions. We need robust, resilient and well-resourced basic public health and emergency services so that we can deal with that.

It is virtually impossible to say how much we need to spend, but the truth of the matter is that, out of our overall budgets, we do not spend very much on prevention. I suspect that, if we asked members to make a guess about that, they would guess way more than the amount that we actually attribute to prevention. Without quoting a number, I note that, as a philosophy, we should collectively seek to slightly increase the amount of overall resource that we spend on prevention each year. As Dr Phin has ably demonstrated, it is so important that we address prevention and keeping people well.

The Convener: Thank you. We are out of time for this part of the meeting, so I thank all the witnesses for their evidence today and for giving us their time. If witnesses would like to raise any further evidence with the committee, they can do so in writing, and the clerks will be happy to liaise with them on how to do that.

11:02

Meeting suspended.

11:07

On resuming—

Subordinate Legislation

Coronavirus (Scotland) Acts (Saving Provision) Regulations 2022 (SSI 2022/261)

The Convener: Agenda item 2 is consideration of a negative instrument. Members should refer to paper 3, which sets out the background. The deadline for a motion to annul the regulations is 30 October 2022. Members will see from the paper that no motion to annul has been lodged to date. Do members have any comments on the regulations?

John Mason: I note the Delegated Powers and Law Reform Committee's comment that the timing is slightly out by a few days. Personally, I find that acceptable, but it is never ideal.

The Convener: Okay. We will have the Deputy First Minister with us on 29 September, so members can raise the matter then if they feel that we need to take evidence on the regulations.

Do members agree that we are content and have no recommendation to make on the regulations?

Members *indicated agreement.*

The Convener: The committee's next meeting will be on Thursday 15 September, when we will continue taking evidence as part of our pre-budget scrutiny.

That concludes the public part of the meeting.

11:08

Meeting continued in private until 11:27.

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