OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 10 May 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
17th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Burns (NHS Scotland)
Richard McCallum (Scottish Government)
Gillian Russell (Scottish Government)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 10 May 2022

[The Convener opened the meeting at 09:31]

Decision on Taking Business in Private

The Convener (Gillian Martin): I welcome everyone to the 17th meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies.

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

Members *indicated agreement.*

Audit Scotland Report: "NHS in Scotland 2021"

09:31

The Convener: Our second agenda item is an evidence session with the Cabinet Secretary for Health and Social Care on Audit Scotland's "NHS in Scotland 2021" report. This session follows the committee's evidence session with the Auditor General for Scotland on 19 April 2022.

I welcome to the committee the Cabinet Secretary for Health and Social Care, Humza Yousaf, who is joined by officials. Richard McCallum is director of health finance and governance in the Scottish Government, Gillian Russell is director of health workforce in the Scottish Government and John Burns is the chief operating officer of NHS Scotland. Good morning to you all.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning. I hope that all committee members are safe and well. All of us are present in person. It is good to be around the table and really good to see everybody.

I am grateful to the committee for its time this morning, and I will make a relatively brief opening statement. I suspect that we will give most of the issues a thorough exploration.

First and foremost, I thank Audit Scotland for its report on the national health service, which was informative, insightful and fair in its recognition of the efforts that the Government has made and on where Audit Scotland thinks the Government and partners must go further in their response to the pandemic in particular.

The report correctly identifies that health and social care in Scotland is at a critical juncture. We are navigating our way out of the pandemic while dealing with case numbers that place continuing pressure on the NHS. It is not just current case numbers that are doing that; the cumulative impact of the pandemic over the past two years continues to put pressure on our health services. In addition, we have seen the emergence of new challenges such as long Covid, which is having complex detrimental effects on people's lives. We will be able to say more about that in this meeting and in the forthcoming parliamentary debate later this month.

There are also challenges caused by the knock-on impacts of the pandemic. We know that we must address the backlog in treatment and care, support our health and social care workforce, and

ensure that everybody can access primary care in a way that supports them and addresses their clinical needs. Addressing those challenges will require a significant changes in how we deliver health and social care while access to those vital services is maintained.

As the Audit Scotland report notes, our workforce has kept going in incredibly difficult circumstances. I—and, I am sure, everybody else around the table—thank our health and social care workers throughout Scotland for the invaluable work that they have done, and for their tireless efforts throughout the pandemic. I recognise the monumental challenges that they have faced. Every single health and social care worker whom I have spoken to has told me that the past couple of years have been the most difficult in their professional careers. That is why we have made £12 million available to support workforce wellbeing, and have put in place a national wellbeing helpline to support staff 24/7.

We are making significant progress on recruitment of staff. Members of the committee will be aware of our recent announcement that we have recruited almost 200 nurses internationally; many others are in the pipeline. They are in addition to the 1,000 additional support staff to work across the NHS and social care. However, more progress is needed. That is why we are taking the necessary steps to recruit more staff and, crucially, why we are not working only on recruitment but on what we can do to retain staff across the NHS and social care.

Audit Scotland made it clear that healthcare and social care should be as inclusive and accessible as possible. Last year, we ran the general practice access campaign, which was shared across social media sites and radio for five weeks, to reassure the public that general practices were open. That campaign emphasised the variety of ways that treatment can be sought, including face-to-face, video and telephone consultations.

Outside general practice, we continue to develop a range of primary care services including, for example, NHS pharmacy first Scotland and NHS 24, which I am delighted to say recently celebrated its 20th birthday. We are also developing more online resources through the NHS Inform website and other channels.

The way in which we access services is changing, and will change, as our digital behaviours change and in accordance with clinical needs. By prioritising clinical resources, we are managing demand and, we hope, supporting people more effectively.

In its report, Audit Scotland rightly identified the importance of gathering and sharing health data to help to ensure transparency and the provision of effective joined-up care across the health and social care landscape. We have also committed to publishing a dedicated data strategy for health and social care. That will be a first for Scotland and we hope to publish it by autumn this year. It is backed by the Scottish Government investing £112.9 million in digital health and care over 2022-23 to help to make the best use of digital technologies in design and delivery of our services.

The NHS recovery plan, backed by more than £1 billion of investment, set out our plans for health and social care over this session of Parliament. That includes providing more than £400 million to create a network of national treatment centres across Scotland, increasing capacity for planned elective procedures and diagnostic care. We are increasing NHS capacity by at least 10 per cent as quickly as possible to address the backlog of care and meet continuing healthcare needs across the country.

We are still dealing with the pandemic. It is not over yet. It continues to have profound effects on the health of our nation and health services up and down the country. Our focus must be on ensuring that we transition out of the pandemic safely, and on tackling the backlogs in immediate and essential care that have resulted.

However, we must also provide access to care in a way that best suits people's needs. We need a strong workforce where wellbeing is protected and recruitment and retention are at extremely high levels. We need to adapt to ensure that new technologies and models of working can help to support more of our citizens with their care as close to home as possible. That is my aim, as Cabinet Secretary for Health and Social Care.

I look forward to delving into the issues in more detail. I am, of course, happy to take your questions.

The Convener: Thank you for that summary. My colleagues will ask questions on the detail of a lot of what you talked about. Some of the Audit Scotland report dovetails nicely with our findings from previous inquiries—in particular, on the workforce—so I imagine that colleagues will ask specific questions from our inquiries into alternative pathways and perinatal mental health.

Will you give a status report on where we are with the care and wellbeing portfolio? Audit Scotland's report mentions the sustainability of the NHS and social care—as they stand and before the pandemic. How might the care and wellbeing portfolio improve sustainability?

Humza Yousaf: On your first comment, I will, of course, take any questions that the committee wishes to ask. If we can give you the detail today, we will do so. As always, I will provide further written detail if that is required.

As I said I my opening remarks, I thought that the Audit Scotland report on the NHS is a fair summary of the challenges and highlights the efforts that the Government has had to make during an extraordinary period. This period will be written about in our history books and learned about in our schools and modern studies classes until long after any of us are around. It has been extraordinary; I again commend all those who were involved for their extraordinary efforts.

You asked specifically about the care and wellbeing portfolio. It would be fair to say that work on that portfolio has been affected by the pandemic: there is no doubt about that. One of my key officials—in fact, a joint director of that portfolio—was working on the test and protect system for us. We had to move crucial resources away from various parts of Government in order to focus on the response to the pandemic.

The work is at the developmental stage. Officials are working to define the intended scope. There are a number of workstreams, which I will touch on. We are clear that the work of the care and wellbeing portfolio must be broader than just healthcare, and that how it interacts with other portfolios and other departments in Government will be crucial. The first meeting of the internal care and wellbeing portfolio board took place late last month.

Your question about sustainability is absolutely on the money. Prevention will be a key element of the care and wellbeing portfolio. The committee has often spoken about the importance of that agenda, which is a vital part of the recovery and renewal of the NHS and social care. The care and wellbeing portfolio will be critical to that and will help to make our services more sustainable. If we stop people going into our hospitals and acute sites, or if we can keep them there for as short a time as possible if they do have to go there, that will be to their benefit and will help to make our services more sustainable.

The portfolio's approach is still being developed. It has three primary objectives: coherence, sustainability and improved outcomes. You asked about sustainability, which is one of the key objectives. As well as prevention, the care and wellbeing portfolio will also have a big focus on innovation and on developing infrastructure that can drive efficiency and productivity within our health and care systems.

The Convener: I have one more question. I know that we are at the very early stages, but the public has expectations about the future of healthcare and wellbeing. Are we at the point at which we need to evaluate patient expectations about where and how they get their care? The Scottish Government has put a number of things in place, such as alternative pathways. You mentioned NHS 24 and the advice to dial 111 instead of turning up at accident and emergency departments. Is there a still a lot of work to do on managing how people approach their healthcare and use the NHS?

Humza Yousaf: That is an excellent question. I regularly speak about that issue with the chief executives and chairs of our health boards, who have real anxiety about it. For most of us, life feels as if it is back to normal. We can interact with our family, book a holiday or hold a 70th birthday party for our parents and have 100 people attend, if we want to do that. Life, for most of us, feels as if it is back to normal, but the health service is still under extraordinary pressure. I do not need to tell people in this room about that: you know it because you are close to it.

People whose lives have gone back to normal are asking why it does not feel as though their health service has got back to what it was like before the pandemic. There must be honesty. I am honest to the best of my ability; there must be honesty across the board that it will take not weeks or months, but years for our NHS to recover, because there have been two years of accumulating challenges.

I do not pretend that there were no challenges in the health service before—there were. However, issues have undoubtedly been unbelievably exacerbated by the pandemic, and not just in the health service, but in social care.

09:45

It is important for us to be up front and honest and to manage expectations, but also to be ambitious. We are ambitious, and our recovery plan is a demonstration of that ambition. From conversations that I have with my health board colleagues and integration authorities about social care, I know that they all want to be ambitious, but realistic, too.

There is a bit more work to be done—John Burns and I speak about this regularly—on cementing our delivery milestones on planned care in particular, because we know how long people have been waiting for some elective procedures. We will publish that work in due course. I hope that it will set a realistic but ambitious timescale for recovery. You are right that we must be up front and honest about the scale of the challenge and how people access their services.

The Convener: Sue Webber has questions on NHS reform.

Sue Webber (Lothian) (Con): You mentioned that we must change the way that we deliver our health and social care while maintaining access to

services. You have also said that you and John Burns are still discussing how the recovery plans will demonstrate ambition for reform, but that there is still a lot to do on cementing milestones for that delivery plan. As you said, it has been 8 months since the Scottish Government published the recovery plan. What is your assessment of progress, if any has been made, since its publication?

We all understand that there is no quick fix, but the daily statistics on accident and emergency, cancer, delayed discharges and diagnosis are bleak. Is the plan working? What confidence can we have in it?

Humza Yousaf: The question about the recovery plan is fair. It is purposely a five-year recovery plan. We will, of course, update Parliament yearly, as the plan says; that update will happen when Parliament returns from the summer recess, which will be a year since the plan was published.

Ms Webber, and I suspect everybody around the table, would accept that we are not out of the pandemic yet. Not only are we not out of it, but the most recent wave of the pandemic that we dealt with has been the most challenging wave—it has been relentless. In relation to the alpha and delta waves of the pandemic—the early variants of Covid—we knew that a wave would hit us really hard for two to three months, after which we would hope to get out the other side and try to recover, but we have had wave after wave after wave.

The omicron wave hit us around December, then omicron seamlessly transitioned into BA.2, which was an even more transmissible variant of a sub-lineage of omicron, and we exited that wave only recently. That wave lasted for four or five months during the height of winter pressures. It was not its severity—it was less severe than previous variants—but its transmissibility that was the issue. That wave knocked out entire wards, including orthopaedic wards, in hospitals across the country, so there is no doubt that recovery has been hampered.

The foundations of the recovery plan are solid—for example, we are doing work with the centre for sustainable delivery to ensure that we drive innovation, and we are working on our national treatment centres. We hope to have a number of NTCs on board in the next 18 months. I recently announced the purchase of Carrick Glen hospital, which will not come on board during those 18 months, but it will be a crucial national treatment centre when it opens.

When we have lulls in pressure, the NHS has been able to recover to some degree. For example—John Burns will correct me if am wrong—the last monthly statistics that were published showed around a 17 per cent increase in the number of performed operations. The NHS is able to recover. However, I will not lie: recovery will be difficult and tough, and the biggest threat by far to recovery is future variants of the virus.

Nonetheless, I think that our recovery plan will deliver. I suspect that that is why the other nations of the UK published similar recovery plans after ours. The recovery plans of the UK Government and the Welsh Government are not at all dissimilar to ours. Everybody recognises that things will not be fixed in a year but will take time.

Sue Webber: You mentioned that the NHS is under pressure; we know that. However, it is always under some form of pressure, and it was always under pressure during all the years that I worked in that environment before coming to Parliament.

The Audit Scotland report notes that

"There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out."

Given the scale and complexity of the challenges that face Scotland's NHS, do you agree that much greater detail is needed if we are to get the NHS back on an even keel?

Humza Yousaf: I will make a couple of points. First, although I do not disagree that the NHS and social care are probably always under some form of pressure, I note, to be fair, that if you speak to anybody working in health and social care, they will tell you that the past two years have been unlike anything that they have ever faced in their lives. I talk to nurses and doctors who have been working in the NHS for four decades and longer. They tell me that, in the 40 years for which they have been working in the health service, they have never experienced anything like the past two years, and that nothing has even come close to it. There is pressure and then there is pandemic pressure; pandemic pressure is above and beyond anything that we have ever felt before.

On the question about more data—[*Interruption*.].

Sue Webber: The question was about detail, not data.

Humza Yousaf: Data is a really important part of the detail. I will come back to the question about more detail in a second; data is crucial to that. That comes across from the Auditor General in the report, which says that there must be more transparency in respect of data. That will help us in terms of the detail that we will bring forward.

We will provide even more detail than we already have, including on the workforce. We are waiting for workforce plans from health boards and

we plan to provide more detail on the three-year projections this summer. We will also provide more detail in the form of the update on the recovery plan that we have promised to provide this summer. As I said, data is absolutely crucial to that.

The ambitions of the recovery plan were well recognised in the Audit Scotland report.

Sandesh Gulhane (Glasgow) (Con): Good morning, cabinet secretary. When I see a patient in general practice and, for example, organise an X-ray or put them on to a waiting list to see a hospital consultant, the first question that they always ask me is how long the wait will be.

I know that, along with Audit Scotland, the Public Audit Committee has highlighted that, stating—I paraphrase—that NHS boards should publish data on performance to enable transparency on how NHS boards are managing their waiting lists.

Patients and doctors want to know how long patients have to wait. Why can we not have in the future—in the plan—indicative waiting times that are relatively live, so that we can all go on a website and see how long we need to wait?

Humza Yousaf: The plan would be to have that data. It is a fair expectation for the patient and for GPs or those who work in our health and social care system to have.

We expect to publish data around clinical prioritisation in the late summer of this year. That is a new policy that has been put in place to ensure that the public—you gave the example of your patients—will be able to see how long they will have to wait. However, it will probably give a range as opposed to an exact date.

We are working closely with Public Health Scotland and boards to develop the infrastructure in order to collate and publish that data. It is an ambition of ours to have that available in a way that is easy to find and understand for both the patient and the healthcare professional.

Sandesh Gulhane: When do you expect that to be online?

Humza Yousaf: We intend to publish that data in late summer, but we will have to add to it. We will continue to have to ensure that it is live, which will be an iterative process, and where we can add to it and develop it even further, we will do that. We expect the first cut of the data on clinical prioritisation to be published in late summer.

Emma Harper (South Scotland) (SNP): Good morning. As we come out of the pandemic, I am interested in the reform process and the use of technology that we have already. People have adopted the NHS Near Me service, which means that they can engage remotely with their doctor, whether that is a respiratory doctor, a GP or whomever. I assume that it will be part of the renewal and reform process to continue to use the technology and innovations that have already been developed, in order to support people to engage with their GP and their other doctors in the way that they choose.

Humza Yousaf: Yes, we must embed that technology in our system. We built on some of that technology out of necessity. Near Me existed before the pandemic, but it was used significantly more during the pandemic than it had been previously.

The issue that you raise comes back to the convener's question about being up front and honest with people about how access to services is provided. We will work with GPs to try to increase the number of face-to-face appointments, but the hybrid model—which includes telephone and video consultation—will be part of access to general practice.

As Ms Harper will be aware, we published the digital health and care strategy in October last year; I am sure that committee members will have seen it. That goes to the heart of what our digital ambitions are in relation to health and social care. The Public Audit Committee highlighted the fact—I am paraphrasing slightly, of course—that it would be a wasted opportunity if we did not embed some of those technological advances in our response to and recovery from the pandemic.

Emma Harper: When it comes to screening such as bowel cancer and cervical cancer screening, if we screen people early, we can diagnose early, which means that the treatment can be more efficient and beneficial. Cancer Research UK said in its briefing that statistics for Scotland have shown that, before Covid, the uptake of bowel cancer screening had increased.

I support continued consideration of how we can improve uptake of bowel cancer and cervical cancer screening, and I know that self-sampling for cervical cancer is in the pipeline.

Humza Yousaf: The committee could have a whole separate session on screening. I want to commend, on the record, our colleague Edward Mountain MSP, who I thought spoke very bravely and with great humour about his bowel cancer journey. I managed to speak to him privately to share my admiration for that. He reminded people about the importance of returning the screening kits, because early diagnosis can save lives. Of course, we wish him all the best with his recovery.

Our work on screening is hugely significant and our decision to pause screening for a few months, which we took early on in the pandemic, was one of the most difficult decisions that the Government

had to make during the pandemic. The recovery of screening is an important part of our recovery plan. There are some elements of it that are not yet fully recovered. We are working on recovering self-referral for breast cancer for women who are 71-plus by September this year, but there is still work to do.

The use of digital is, of course, important, but we also need to make sure that screening is accessible as close to people's homes as possible. That is really important in our remote rural and island communities. In relation to cervical cancer screening, it will be really important to have mobile screening units of the kind that are used for breast cancer screening around the country. That will enable us to ensure that such screening is as accessible as possible as close to home as possible, which will be key to helping us with our recovery.

The Convener: We will now focus on workforce planning. We have alluded to it many times before, but David Torrance has specific questions on it.

10:00

David Torrance (Kirkcaldy) (SNP): Good morning. The sections of Audit Scotland's report on staffing and recruitment state that it would be "challenging to achieve" the plans to recruit and retain staff due to the historical difficulties that have been faced by the NHS in the past. Is the cabinet secretary confident that the national workforce strategy will be able to meet the workforce availability and workforce wellbeing needs of the NHS?

Humza Yousaf: Yes, I am confident of that for a couple of reasons. First, on the wellbeing aspect, I am pleased that Audit Scotland's report recognises the Government's focus on wellbeing, and we will have to continue to focus on that. Paragraph 89 of Audit Scotland's report says that:

"There is clear commitment at Scottish Government and NHS board level to support staff wellbeing, and it features prominently in the NHS recovery plan."

To me, the fact that Audit Scotland has recognised our focus on wellbeing speaks volumes. I am absolutely unapologetic about that focus, because staff wellbeing is at the core of retention. Pay and terms and conditions are all important, but people who tell me that they are thinking of leaving the NHS or the social care sector say that it is the wellbeing and mental health pressures that are forcing them to think about whether to leave the profession. I am desperate to try to avoid people leaving because of those reasons; therefore, wellbeing will be central to our plans.

Our workforce strategy was recently published and I remind members that it was co-produced with the Convention of Scottish Local Authorities, which is important, particularly for the social care aspect of it. Workforce planning will be challenging—there is no getting away from that. We will do everything that we can to try to ensure that we increase, where necessary, the pipeline of students that are coming through in staffing cohorts. We will do what we can to recruit domestically, which will be a significant part of our strategy.

We will also recruit internationally, which is not a panacea, but will help to bolster some areas of our workforce. Recruitment will be difficult, because for some specialisms—for example, medical oncology—there are staff shortages not only in Scotland, but globally. Of course, we are not the only health service in the world that is facing those challenges; we are all going to be trying to recruit more nurses and other staff. We need to make sure that the data that supports our workforce plans is as accurate a projection as it possibly can be—the Audit Scotland report focuses on that in some detail.

David Torrance: I was just coming to that. How will the implementation of the strategy be monitored, evaluated and reported?

Humza Yousaf: It will be monitored, evaluated and reported, of course. The current plans are to receive updated projections from our local health boards. We will then publish the projections for our workforce in more detail. We will continue to make sure that the Parliament is regularly updated, and I am sure that those workforce plans will be regularly scrutinised by the committee, as well as, I suspect, Parliament as a whole. It is our ambition to be transparent and open about the process, and also about the challenges. I have just articulated some of those challenges to Mr Torrance, but I think that we should be up front that this is ambitious and it will be challenging.

David Torrance: How have Brexit and the United Kingdom immigration policy affected the ability of the NHS to recruit additional staff? The cabinet secretary mentioned that the NHS has recruited 200 nurses internationally. Has the NHS faced any difficulties in being able to do that?

Humza Yousaf: I have tried not to stray into politics too much. Brexit has undoubtedly had an impact, which has been recognised by anyone who is involved in social care, in particular. Any MSP who has visited care homes in their constituency over the past year will have seen the differences in workforce demographics.

Any social care provider that we speak to—whether it be a small independent, a third sector organisation or local authorities that have in-house provision—has clearly said that Brexit has had an impact.

On the flip side of that, I was pleased that, after considerable pressure from the Scottish and Welsh Governments, and, I suspect, from providers in England, the UK Government made changes to its shortage occupation lists in relation to social care, but that does not go far enough.

Social care is a real concern of mine. I have talked about the workforce, and of course we have ambitious plans around the national care service. No doubt we will, in future meetings, get into the detail of that. We cannot wait until the national care service becomes fully operational at the end of the current parliamentary term; we have to take action now. There is no getting away from the challenges caused by decisions that have been made elsewhere that are having an impact here in Scotland.

The Convener: On the other side of things, with regard to our home-grown future workforce and people wanting to enter the profession, the Scottish Government has put in place bursaries for paramedics, nurses and midwives. Has any analysis been done of the impact that that has had on encouraging people to go into the profession?

Humza Yousaf: We have positive data on the increase in intake of student nurses and midwives, and that data speaks for itself. It might be difficult to say that the bursary has caused that increase but it would be fair to say that the package of support that we give to students, including bursaries, has been a factor in that.

There are also challenges, and the paramedic bursary is a really good example of that. There was an excellent campaign that was run by a number of student paramedics, and when I met them, they were very clear that, without the bursary, they did not think that they could continue. The anecdotal data is there. The workforce numbers that we have on the student intake are positive.

There are also some well-known and well-rehearsed areas where we have struggled with intake. We know and have often talked about the level of vacancies in our nursing cohort in particular, and we will work hard to fill those. However, we are in a competitive place because people in health systems around the world are looking to do the same thing. I think that Scotland is an attractive proposition, with the best-paid staff in the UK. Scotland offers an excellent lifestyle and remote, rural and island Scotland, in particular, offers a lifestyle that many people seek. We are going to have to maximise every one of those potential avenues to meet the ambitions of our plan.

Paul O'Kane (West Scotland) (Lab): I heard the cabinet secretary's initial answer to David Torrance's question on workforce pressures, and his answer about Brexit. When the Auditor General for Scotland gave evidence to the committee, he spoke about historic problems with staffing. He said:

"We know, and have previously reported, that the NHS has, historically, struggled to achieve all its staffing ambitions."—[*Official Report*, *Health, Social Care and Sport Committee*, 19 April 2022; c 3.]

Will the cabinet secretary acknowledge that there has been something of a historic failure to deliver a workforce plan, and that there were failures in meeting staffing targets before the pandemic?

Humza Yousaf: We have a good record on NHS staffing. We have grown the NHS workforce by more than 20,500 since September 2006. That is 10 consecutive years of growth. We have record levels of staffing across medical and dental consultants, nursing and midwifery, and allied health professional groups. We also have the best paid staff. Our record is therefore good.

On the flipside of that, there have been challenges around our workforce planning and projections, which can be difficult at any time and blown off-course when we are hit with a pandemic—there is no doubt about that. That is why the projections and data that we expect to receive from health boards this summer will be hugely important in ensuring that our workforce plans meet the future demands on our health service.

Gillian Russell is the director of the health workforce in the NHS, and she will be able to add more, if Mr O'Kane is happy with that.

Gillian Russell (Scottish Government): I will continue the point about the planning that we have asked for. We have asked health boards to provide us with workforce projections based on population need. That will give us a much better understanding of the nature of the workforce that we will need for the future.

Good work was done back in 2019. For the first time, we published an integrated workforce plan across health and social care. As we look ahead, it is important that we continue to hold the health and social care workforces together and plan on the basis of the totality of the integrated workforce that we need.

We have said that we will report later in the year on the planning around the summer work that we get back. It is important that the workforce strategy that we have just published sets out a long-term framework for the workforce and that it also contains a clear commitment to a delivery plan for the short, medium and long terms. It is within those short, medium and long-term actions that we will start to see the delivery of that strategy. We will report on that regularly.

Some of the work that we are doing now—for example, those workforce projections—will start to drop into the delivery parts of the workforce strategy. That is the sort of thing that we will be reporting on to this committee and others as we move into the future. I hope that that is helpful.

Paul O'Kane: I will continue in that vein. We have seen evidence in the Audit Scotland report that data and planning have not been adequate. That answer suggests that we have to do a lot more to understand and profile where we are.

I return to the cabinet secretary with a question about nursing places and vacancies. There are 6,674.4 whole-time equivalent nursing and midwifery vacancies in the NHS, and we have heard some of the cabinet secretary's reasons for the challenges in that. Will he also accept that the reduction in the number of nursing training places—a decision that was taken by his predecessor—has exacerbated those challenges?

Humza Yousaf: I appreciate what Paul O'Kane is trying to do, but—

Paul O'Kane: I am trying to ask you a question and get the answer.

Humza Yousaf: I go back to what I think is a good record during our time in Government. Our record speaks volumes.

When it comes to recruitment and trying to look into the future—or even looking at the present vacancies—we have to create vacancies in order to expand the workforce. Again, I will be able to write to the committee with more detail about what percentage of recent vacancies have come on board recently. Actually, Gillian Russell has helpfully provided that: 77 per cent of the nursing and midwifery vacancies that were reported in December 2021 have been recorded in the past few months. That is reflective of the extent of the new posts that have been created.

Those new posts are part of the workforce expansion, but they do not account for all vacancies by any stretch of the imagination. Those remaining vacancies give me a level of concern. However, to go back to my previous point, this Government and successive health secretaries have a good record of increasing and expanding our staffing.

However, it is not just about expansion; it is also about retention. The nurture pillar of our workforce strategy is key to that. In the reform space, it is also about what we ask those who work in the health service to do. There is a question about infinitely growing our workforce in the future. I do not think that anybody would suggest that that will be possible. However, we can ensure that what we ask our workforce to do meets the needs of the public and patients.

We have a good track record. There is no doubt that there have been challenges to workforce planning in the past but, with our current strategy in place, I hope that we will be able to mitigate some of them.

10:15

The Convener: A number of colleagues want to ask about workforce planning, so I must ask for short, sharp and succinct questions. I call Emma Harper, to be followed by Sue Webber.

Emma Harper: I will be quick, convener. The Scottish graduate entry medicine—or ScotGEM—programme, which was launched in 2018, is unique to Scotland. We have just seen 54 graduates come out of it, and it is part of the way in which we are trying to address GP recruitment in rural areas. Can you comment quickly on how successful ScotGEM has been for Scotland?

Humza Yousaf: It has been really successful. Taking my cue from the convener's comment about being succinct, there is little for me to add, given that Emma Harper has rightly mentioned some of the data on the programme. We can build upon initiatives such as ScotGEM, the rediscover the joy project, golden hellos and the work that we are doing on the back of Sir Lewis Ritchie's report into a centre for remote and rural healthcare. All those initiatives are important for recruitment and retention, particularly in our remote, rural and island settings.

Sue Webber: Retention, which you mentioned and which we have talked about at length, is the key issue. According to damning research by the Royal College of Midwives, midwifery is at breaking point. Three out of four RCM members in Scotland are considering leaving their posts, while 88 per cent are reported to be experiencing work-related stress. NHS boards are being encouraged to optimise the retention of midwives, but midwives tell us that the profession continues to be in crisis. What immediate action is the Scottish Government taking to respond to midwives' concerns right now, and to improve retention rates and midwives' health and wellbeing?

Humza Yousaf: I spoke to Jaki Lambert of the RCM yesterday, and we had a good and detailed discussion about the very points that Ms Webber has raised. I do not know whether the staff survey has been published yet, so I will refrain from going into detail on it, but, as I understand it, one of the best things that we can do to alleviate some of the concerns is to control Covid transmission. It is very clear from staff responses that the pressure of the pandemic has been unlike any other pressure that they have faced before, and if we have can control the pressure of Covid, it will stop midwives feeling anxious every day they go on shift about whether

they will be moved to a different ward or whether any given unit at any given time will have the appropriate number of midwives and nurses. Controlling Covid transmission will help to alleviate that significant pressure.

Investment in wellbeing will also be important, as will as giving our midwives and, of course, other NHS and social care staff the time to access those wellbeing resources. I therefore made a commitment to the RCM that we would continue to invest in wellbeing.

The third point, which was made quite strongly to me, was on the importance of time for training and educational and professional development, which, again, have been impacted by the pandemic. Controlling the pandemic and community transmission will allow us to begin to alleviate some of that pressure, so that our midwives can dedicate more of their time to training and competency.

Sandesh Gulhane: Where are the bottlenecks on the patient journey through the NHS?

Humza Yousaf: A number of bottlenecks are the result of the pressures of the pandemic. Some people will say to me that they find accessing primary care a challenge, and we know that there can be challenges in that respect. I believe that you used the example of a patient waiting for an X-ray, but access to diagnostic testing, waits for elective procedures and screening that we have previously talked about have all been impacted by the pandemic.

There is no doubt that there were challenges with waiting lists before the pandemic. I am not suggesting that you are saying so, but any suggestion that the pandemic has not significantly exacerbated those problems would be inaccurate. Unfortunately, because of the pandemic, there are bottlenecks across the system.

Carol Mochan (South Scotland) (Lab): In the interests of time, I would just like to hear the cabinet secretary make a commitment on the important issue of allied health professional staff. They have a really important role to play in the reform of the NHS, but they face significant recruitment and retention problems. I raise that to ensure that the team sees it as an important part of the overall plan for the NHS.

Humza Yousaf: That is vital. There is not much for me to say except to agree ferociously with Ms Mochan on that point. We know how important those allied health professionals are, particularly when we think of the work that they do with GPs and multidisciplinary teams, which is just one example of how important they are. They are clearly part of our plan for the recovery of the NHS and social care.

The Convener: We move on to talk about long Covid. Emma Harper has some questions.

Emma Harper: I am interested in how we will support people who have post-Covid syndrome. Many different symptoms seem to be demonstrated, including neurovascular, cardiovascular, gastrointestinal and musculoskeletal ones. There is a wide range of symptoms. What are we doing in Scotland to support people with long Covid?

Humza Yousaf: That is a good question and is a focus of the Audit Scotland report. I will respond to Ms Harper and suspect that we will go into more detail in the forthcoming debate on the subject.

I regularly meet stakeholders, particularly those who have lived experience of long Covid. I also meet Long Covid Kids, which is an important organisation that represents young people who continue to be affected by the long-term impacts of Covid. It would be fair to say that those stakeholders feel that there is no consistency in approach, either from a geographical perspective or within different parts of the healthcare system. That is a key challenge that they have raised with me.

What are we doing to support them? The member will be aware that we try to provide as much of the best guidance that we can to our clinical colleagues in healthcare. Our primary care colleagues in particular will often be the front door for people who are suffering from long Covid. The notes in the Scottish Intercollegiate Guidance Network guidelines say that services for people with long Covid

"may be provided through integrated and coordinated primary care, community, rehabilitation and mental health services."

and they note that

"areas have different service needs and resources"

so there is not one model that will fit all areas. Different approaches are taken in different parts of the country.

You will know that we announced a £10 million long Covid fund to be spent over the next three financial years. We will soon be able to give details about how some of that funding will be distributed.

One key thing that we have tried to do to deal with the question of consistency is to establish a national strategic network for long Covid. The network is managed by NHS National Services Scotland and brings together clinical experts, GPs, allied health professionals and specialists in secondary care. Most importantly, it brings together those with lived experience, who are informing us on how that funding should be spent and where the gaps in provision and services are.

The network will continue to examine and act as a check on the work that we are doing on long Covid.

There is a lot more to do in that space. The last thing that I will say is that we are still learning about the long-term impacts and effects of Covid, so we have provided funding for research. That research will take time and it might not lead to immediate results or benefits, but it will be critical to our understanding of how we treat and manage long Covid in the future.

Emma Harper: Long Covid networking will take place virtually with clinicians and professionals. We are not necessarily talking about bricks and mortar clinics or spaces; we are also looking at virtual engagement, as is happening in England. Is that part of how we will support people?

Humza Yousaf: I go back to the guidance note, and the point that there is not one model that fits all. For example, if a health board wanted to set up a clinic based on the Hertfordshire model, it could do that. As I have said, I will not pre-empt any funding decisions that are still being considered. We will make those decisions fully public and transparent soon. It is up to individual health boards to understand the needs of those whom they serve and what is the best model that they can put in place.

I know that the approach works exceptionally well in some places. I spoke to a patient called Pamela in the NHS Greater Glasgow and Clyde area who has had exceptional treatment and care for the long-term effects of Covid. She could not speak highly enough of the physios who have helped her during her care and treatment. Equally, I have spoken to people who say that the support that they have received for the long-term effects of Covid has been inadequate. That is why the strategic network must ensure that there is consistency across the country, and my job is to ensure that it is resourced effectively.

Emma Harper: Across the country, we have urban and rural and remote areas, as well as islands. We have a different geography so, when it comes to supporting people, we cannae just lift and shift a model that might be used elsewhere, although I suppose that we can learn from what is being done in France, Belgium and Germany as well.

Humza Yousaf: We should learn from good practice across the UK, Europe and the world, when we can. There will absolutely be good practice and, when it is appropriate to replicate that in Scotland and we can do so, we will do so. I have a high degree of trust that our health board colleagues will be able to deal with, treat and provide care for people with long Covid in a way that suits their demographic and needs, particularly those in remote, rural and island areas.

No doubt the picture will evolve, and I will continue to keep Parliament updated. The use of technology will be important, but equally, I suspect that, as our understanding develops through research, our approach will also develop.

Emma Harper: Thank you.

Sandesh Gulhane: Cabinet secretary, I am glad that Pamela had a great experience but, unfortunately, she is a bit of an exception rather than the rule when it comes to long Covid. You mentioned the Hertfordshire model, which could be used throughout the country. In that model, much of the work is done virtually, because that is how patients want to access the clinic. Many long Covid patients are too tired to physically come into a hospital or clinic, so they cannot access those. Therefore, despite what we heard earlier, the Hertfordshire model could actually work throughout the country.

One of the big words in the guidelines that you referred to is “may”. Surely we need to get to a position in which, across Scotland, there is a clinic that GPs can refer patients to because, right now, what we have is not acceptable.

Humza Yousaf: I think that there is a difference of view among clinicians. I of course respect your clinical judgment on that, but you would acknowledge that many clinicians have a different view and think that, actually, a one-stop clinic that GPs could refer to would end up taking away resources from other parts of the health service. They think that, actually, we could refer people into a respiratory pathway or another pathway, so there is no need for a one-stop clinic. At the same time, I accept that there is contrary view to that.

In my articulation to Ms Harper, I was trying to be fair and to say that, where there are good models—I purposefully referenced the Hertfordshire model—that we think can be replicated here in Scotland, I have no issue with health boards replicating, implementing and embedding those models in their areas. As I said, once the final decisions are made, which will be shortly, we will be able to give detail about funding in relation to the £10 million long Covid fund. The purpose of that fund is to plug the gaps in provision. The strategic network will help with looking at where the gaps in provision are and whether the funding can help to plug some of those.

10:30

If the health board believes that there should be a one-top clinic, that is fair enough. However, NHS Highland is a classic example of how challenging

running a one-stop clinic might be. I take the point that virtual access can be a key part of that, but many people's expectation of such a clinic would be to be able to see a clinician face to face and have a detailed conversation with them. We have to be up front and say that that model may work in some areas but may not be suitable for others.

The Convener: There is one more question on long Covid. Please be quick, because Paul O'Kane wants to ask a question and we have several other themes to get through.

Sandesh Gulhane: When the Auditor General came before the committee, he said that it will be difficult to evaluate long Covid patients' outcomes and how they get on through the services. Therefore, with the money that is being spent, will you ensure that we embed a way to see how long Covid patients get on with their journey and also to evaluate the outcomes with those published beforehand?

Humza Yousaf: Yes—evaluation will be a critical part of any funding that we give. That goes for any portfolio, but I am particularly keen that evaluation should be embedded with any of the funding related to long Covid, because it is a condition that we are still learning about. I can absolutely commit to there being evaluation but, if you will forgive me, I will take the exact timescales of the evaluation off the table and furnish you with more detail.

Evaluation of the funding of any model is critical, because we are learning about long Covid day by day and week by week. The strategic network will also have a role to play in that evaluation. Everybody in the network is important, but I think that Dr Gulhane will agree that the most important people are those with lived experience. For me, the feedback loop that we have with them will be crucial in any evaluation.

Paul O'Kane: The £10 million fund was announced in September of last year, but there was no spending until the beginning of this financial year. Why was that and what is the long-term strategy for funding this crucial work?

Humza Yousaf: We were always up front about the fact that the funding would be for the next three financial years, one of which we are now in. The reason why we took some time was—not to rehearse the point too often—that it was crucial that we understood where the gaps in provision were. That understanding was informed by clinicians, health boards and people with lived experience and we did detailed consideration of that, which then allowed health boards to bid for money to plug some of those gaps in provision. Therefore, it was very important that that work was done.

I am confident that the disbursement of the first tranche of that money will considerably improve the experiences of people who are suffering from the long-term effects of Covid. However, as I keep saying, it will be a work in progress because we are learning more about the condition and our approach should develop as a result of that.

The Convener: We now address data, with questions from David Torrance.

David Torrance: In a conversation at the weekend, when I was socialising with friends who are all front-line NHS staff, at the mention of Audit Scotland's call for more data their faces fell. They feel that the collection of that data and the time that they have to spend on that distracts them from front-line services. There is a balance to find there, because if Audit Scotland is wanting more and more data, the backlog in front-line services will just get bigger and bigger. How do we get that balance?

Humza Yousaf: That is a very good point. I am pleased that Mr Torrance has time to socialise. [*Laughter*.]

David Torrance: I will not tell you what I was celebrating.

Humza Yousaf: Quite right, and it is nice to get back out socialising now that we can.

The member raises a serious point. A balance needs to be struck. I am conscious of that, because I have asked for a lot of data from our healthcare colleagues during the pandemic and during my year as health secretary. I have asked for a lot of data and the Government has asked for a lot of data. Undoubtedly, that has placed a level of strain on people. We try to get the balance right in terms of how often reporting takes place and what data is being reported on and so on.

When we get into the matter in more detail, the key issue that I hear from healthcare professionals is that barriers still exist to sharing data across the health and social care landscape. That continues to be a significant problem. Last year, we published our digital health and care strategy. That lays the foundations of easing some of that in the future and removing some of those barriers.

We are alive and alert to your point about the need for us to ensure that we have the data that we need while not burdening our health services at a time of extreme charge.

Gillian Mackay (Central Scotland) (Green): Will the forthcoming data strategy directly address the gaps that Audit Scotland identified in primary and community care data, or does the cabinet secretary think that that will be more of an overarching strategy?

Humza Yousaf: That is a really good question. On the gaps or barriers that we see at the moment relating to the sharing of data, work to remove those barriers is already taking place. That does not need another strategy or document necessarily. The issues are well known, we have been working on them for many years and we will continue to try to work through some of them.

If you look at our digital health and care strategy—I was looking at it again this morning—you will see that it has three key aims, the second of which is around the sharing of data and having a system that allows

"staff to record, access and share relevant information across the health and care system".

It is really important that that is done in a way that not only removes the barriers but does so—I will speak frankly—within the financial constraints that we are under.

I highlight page 18 of the strategy, which talks about our digital foundation, the national digital platform and the importance of the cloud-based infrastructure. The strategy is not about upending every IT system across the NHS and social care and replacing it in its entirety with one system; it is about using cloud-based architecture, which can allow you to share information better.

The new data strategy will be an overarching strategy. It will talk about how important it is for people to be able to access their own data, how that data will be safely and ethically managed, safely stored and so on. It will also be an iterative strategy, so it will continue to be developed. It will not delay any of the current work that is being done to address the issue of the availability of data, whether at primary care, secondary care or community level.

Gillian Mackay: What will the strategy do to improve data on health inequalities? We have heard in other pieces of work issues around data specifically relating to different minority ethnic groups for example. I am quite keen that we continue to work on that area to ensure that everybody's healthcare matches the reality of their lives.

Humza Yousaf: The member has consistently raised the issue of health inequality when I have been in front of the committee and it is an important issue for us to focus on collectively.

I will make a couple of points. I go back to my substantial point to your previous question. The work that we are doing around data on health inequalities will not wait for the strategy to be published. We are getting on with that work now. I will give you a couple of examples. You will know that, during the vaccination programme, we ensured that we collected data on people's ethnicity for example. That gives us much richer detail around some of the health inequalities. It is very clear that the uptake of vaccinations was lower among particular ethnic community groups, such as the Scottish African population and, I think, the Scottish Polish population.

Another example is the great work of the primary care health inequalities short-life working group, in which colleagues from the deep-end project have been involved. As you know, the deep-end project involves GP practices that are based in some of the most deprived parts of Scotland. I commend the group's report to all members of the committee, if they have not seen it already.

The data strategy will set the direction for improving data collection and the recording of protected characteristics data, which will enable highly detailed research into health inequalities to be carried out. That will be an element of the data strategy, but I give Ms Mackay an absolute assurance that we are not waiting for that strategy to improve data collection on health inequalities—that work is taking place right now.

The Convener: We move on to questions on prevention and early intervention, which we have partly covered already.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I think that everybody here would agree that improving population health will be a key issue. That involves improving life expectancy—healthy life expectancy, in particular—and physical and mental health and wellbeing. Covid has shown us the importance of that. However, we are still recovering from the pandemic.

As the health and social care sector recovers, how can you ensure that policy making remains focused on prevention and early intervention?

Humza Yousaf: That is a good question. I can give you confidence that prevention is not viewed in isolation in health and social care, although it is, of course, vital to those of us in health and social care. The Deputy First Minister convenes—with a great degree of regularity—a group of cabinet secretaries and ministers that is focused almost entirely on prevention. Our recent announcements on the child poverty action plan are an excellent example of our coming together across a number of portfolios to work hard to deal with the issue of child poverty as it exists, but also to prevent more young people, children and families from getting into poverty, and setting out how we plan to do that. Such cross-Government, cross-portfolio working is vital.

Improving physical and mental health before crisis point is an important focus for us. There is a lot of focus on child and adolescent mental health

services. That is understandable, because there are challenges around CAMHS referrals. I accept that, which is why we will put in significant investment. However, we are also putting significant investment into prevention, before people get to crisis point. For example, we are looking at what we can do in our schools as regards education in and around mental health.

On physical health, too, a lot of preventative work is being done. We are thinking about how we can make physical health opportunities, such as those that are offered by sport, more accessible. I am not talking only about sporting opportunities at the elite level, important though those are. Last week, we celebrated 10 years of the daily mile. My colleague Maree Todd deserves a shout-out for her vociferous championing of that project. We are trying to make opportunities to improve physical health as accessible as possible.

I can give you an absolute assurance that we have—and have had for many years—a laser-like focus on the preventative agenda, but I go back to Ms Mackay's point about our data on the areas of highest deprivation, where, unfortunately, the health inequalities are still too wide. Those areas will be areas of particular focus for us in the coming period.

Stephanie Callaghan: I appreciate the fact that a great deal of work is being done around 20-minute neighbourhoods and having services based in the community, where people are. However, an issue that we have come up against when we have talked to people from the NHS is the fact that they often tend to be driven by activity on which they have targets, and that it can be much more difficult for them to prioritise preventative work. What can be done to empower them to ensure that such work is a top priority? Is monitoring and evaluation carried out that we could look at?

10:45

Humza Yousaf: A lot of our funding streams are focused on preventative spend. I commend the third sector for the role that it plays. We often talk about the important role of our public bodies, which of course play an exceptionally important role in all this, but the third sector also has a vital and critical role to play in the prevention and preventative agenda. Our funding will often be targeted in the preventative space and—as I mentioned in a previous answer—will always be evaluated in relation to outcomes and what it is achieving.

We also have an important role in relation to policy making and what can help in the preventative space. For example, I am thinking about some of the action that we have taken on smoking cessation, obesity and alcohol consumption. Our policy also has to be focused in the preventative space.

That is also why I am very keen that, when we talk about health and social care, we do not lose focus on the social care aspect. The more we can resource our social care and care in the community, the more we will prevent people from coming in the front door of our hospitals—and, even if they do have to come in the front door of our hospitals, the more we can hope that they are there for a relatively short period of time. Certainly, we would not want to see the level of delayed discharge that we are seeing at the moment, which I fully accept is far too high.

There is therefore an important role for funding and for the third sector and public bodies. However, Government leads on this agenda, and I hope that our own policies give some reassurance that it is a top priority for us.

Stephanie Callaghan: Progress on life expectancy specifically has stalled over the past period. Are there any specific plans to revitalise that progress, and to monitor and evaluate it?

Humza Yousaf: Stephanie Callaghan is absolutely right to make the point that progress on life expectancy has stalled. Improving mental and physical health—which are obviously often linked—and improving access to opportunities to improve one's own physical and mental health will be critical. That is why our recovery plan is so important. To be frank, because people have not been able to access services in the way that they would have pre-pandemic over the past two years, people are undoubtedly attending our hospitals with higher acuity. They are deteriorating in their own conditions if they have been on waiting lists for too long, and if a person does not get a CAMHS referral in good time, their mental health is of course in danger of deteriorating.

Again, the preventative space is therefore integral to our recovery. However, the challenges are significant. That is why the care and wellbeing portfolio is also hugely important. I am happy to give the committee continued updates on how we are evaluating that. Different pieces of that work will be evaluated in different ways. For example, we have promised to update on the recovery plan yearly, but there is a different evaluation process for funding streams. Maybe I can set some of that out to the committee in further detail.

The Convener: Carol Mochan will do a deeper dive into health inequalities.

Carol Mochan: Although the previous couple of themes have covered the issue, I note that the Auditor General was critical of the Government's overall strategy for addressing health inequalities, particularly around disability and among people

from deprived backgrounds. The pandemic is acknowledged but the report also very much acknowledges that those are on-going health inequalities.

Has the Government managed to pull together an overarching strategy to look at health inequalities? If so, what will it measure? On top of that, has the Government considered other measures that it can use—perhaps other powers that it has but is not currently using—to make a difference in an area that is of the highest importance to it?

Humza Yousaf: I recognise from the outset that Ms Mochan has had a consistent interest in the issue of health inequalities. I share that interest, and it goes to the heart of what we are doing right across Government. If she has not seen it, I commend to her the health inequalities and primary care report that I referenced to Ms Mackay. I appreciate how much paperwork members will see on a daily basis, but we would be keen to share that report with the committee. If members have not seen it, we will pass on the link.

It is really important that the Government considers the report and its recommendations, which provide a strong basis for dealing with health inequalities at a primary care level. As we know, primary care is often the first port of call. We have invested in community link workers and have promised to provide further investment in mental health and wellbeing workers in every general practice.

I will not give a long list of what we have done with the powers that we have—I will perhaps just give a short list. We have worked across portfolios. In education, we have provided free school meals. In early years, we have increased the number of hours of free childcare, with a particular focus on at-risk and vulnerable young people. We have invested in affordable housing. In healthcare, we have delivered a number of preventative programmes and policies in the public health space, as I mentioned. There is also concessionary travel, free personal care and so on.

You are right: we are taking a cross-Government approach to tackling inequalities. However, I have to be up front and frank. As I hope Ms Mochan will accept, there is only so much that we can do when we have a UK Government that is not adequately addressing the cost of living crisis, fuel poverty and the energy crisis. The passive nature of how the UK Government is tackling the cost of living crisis comes on the back of 10 years of really difficult austerity.

Some of the powers are, absolutely, in my hands, and Ms Mochan is right to challenge me to go further and use them more. We have often done that. However, to be frank, there is only so much that I can do to mitigate the impacts and effects of decisions that are made elsewhere.

Carol Mochan: We obviously agree that the cost of living crisis is very significant, and we do not disagree about the impact of the Westminster Conservative Government. I thank the cabinet secretary for the commitment that we will use all the powers that we have in Scotland. That is very helpful.

The Auditor General spoke about the progress of Public Health Scotland's work. Can you give a bit of feedback on how that work is going?

Humza Yousaf: I hope that most members recognise the incredible work that Public Health Scotland has done over the course of the pandemic. That includes the amount of data that it has provided and its incredible work across the range of services that it provided in response to the pandemic. We did not know that we would be hit by a pandemic, which has meant that some of the work that we wanted Public Health Scotland to do when the organisation was conceived has stalled. There is no getting away from that.

However, I am pleased that my recent conversations with Public Health Scotland have shown that it has been able to pivot slightly away from the pandemic response, although it has not been able to pivot entirely away from that, because the pandemic is still with us. Given that we are moving into an endemic phase, Public Health Scotland is able to do more work on the issues that Ms Mochan has raised, and I give an absolute assurance that those issues are a clear focus for the management and chair of Public Health Scotland.

The Convener: Paul O'Kane has some questions about NHS finances.

Paul O'Kane: The Audit Scotland report states that

"The NHS was not financially sustainable before the Covid-19 pandemic"

and that six boards require additional financial support from the Government or to use non-recurring savings in order to break even. Is the cabinet secretary confident that those boards will be able to achieve financial balance in 2022-23, or is it likely that on-going support will be required? What is his assessment of the issues that are being experienced by the boards? Is it a case of weak financial management, or is a lack of adequate resourcing a more fundamental issue?

Humza Yousaf: In responding to the pandemic, we have ensured that every health board has

received the support that it has needed. When health boards have requested additional support, we have been up front in making it available.

However, there is no doubt that the challenges of the pandemic have not made it any easier for the boards that were escalated in relation to financial sustainability prior to the pandemic. Therefore, significant support has been provided to the boards. I am not going to give you an absolute assurance on how things will end up at the end of the financial year, but there will have to be continued work with those boards in the period ahead.

Our aim and ambition in providing that support is to de-escalate the situation. That is the entire purpose of providing the support. You will be aware that, when boards are escalated, we ask for a significant amount of reporting in addition to what we would ask for from any other health board. I am confident that the boards will de-escalate in good time, but I also make the point that the pandemic has made achieving financial sustainability more challenging.

Richard McCallum might want to add something.

Richard McCallum (Scottish Government): As the cabinet secretary said, all boards received additional financial support through the pandemic. We provided that additional funding for costs associated with bed capacity and the vaccination programme, for example.

Three of the six boards that are mentioned in the Audit Scotland report—NHS Ayrshire and Arran, NHS Borders and NHS Highland—were escalated for financial reasons before the pandemic. The work that we did at the end of 2021-22 was designed to enhance those boards' financial reporting to ensure that, given where they were before the pandemic, there was a continuing focus on financial recovery. We had also noticed some differences in the position of the three other boards—NHS Orkney, NHS Dumfries and Galloway and NHS Fife—compared to that of other territorial boards, so the approach was to have some enhanced reporting to ensure that those boards were on track with their financial plans so that, in 2022-23, they can deliver the financial plans that they have set out.

Paul O'Kane: I do not think that anyone would deny that the pandemic has exacerbated the pressures. I was just pointing to the fact that the Audit Scotland report says that there was no financial sustainability prior to it. The committee will be keen to hear an update on the progress of the boards to which I referred when we get to the financial year end.

I will ask more broadly about the increase in funding. The Scottish Government committed to a £2.5 billion increase in funding for health and social care over the parliamentary session. However, the medium-term framework for health and social care has not yet been updated. In the absence of any medium-term financial framework, how can the cabinet secretary be confident that the additional funds that were committed will be allocated and used effectively? When will the updated medium-term financial framework be published?

Humza Yousaf: On your latter point, we recognise that the framework has to be updated, particularly in the light of Covid and some of the challenges that that has brought. We have not yet committed to a specific date by which it needs to be published, given that we are just coming out of the immediate pressures of a pandemic response because of the omicron and BA.2 wave. However, we recognise that the framework needs to be updated and published.

Remember that the medium-term framework does not set our budget; it gives us an envelope, and then it is for us to prioritise what the budget will look like. That is informed by our key policy priorities and, for example, how we align with the national performance framework.

On your question about confidence in the funding and the fiscal framework, I point to a recent joint study by the London School of Economics and *The Lancet*, which suggested that a 4 per cent real-terms growth in healthcare costs is to be expected if we are to improve the quality of care and the terms and conditions of the health and care workforce. That is in keeping with the assumptions that underpin the current medium-term financial framework.

That and other independent research will inform our review. We will update the medium-term financial framework and publish it after the resource spending review. I hope that that makes sense to members.

The Convener: We have a final question from Evelyn Tweed before we wrap up.

Evelyn Tweed (Stirling) (SNP): The Auditor General noted that reforming lines of accountability might encourage collaborative working across health boards. He also noted that individual accountable officers could be measured on

"the delivery of performance for their own organisation, as opposed to the delivery of wider outcomes."—[*Official Report*, *Health, Social Care and Sport Committee*, 19 April 2022; c 23.]

Is that something that the Scottish Government is exploring?

Humza Yousaf: We will explore that. Every report by the Auditor General on the NHS

deserves such consideration. I am keen that we get the balance right. There is reform that is exceptionally important for delivery of service, but reform of governance and accountability is also really important. However, we must not end up so involved in reform that we get distracted from the immediate pressures of getting through the backlog, given the length of time that people have had to wait for various elective procedures.

Accountability is important. Although I cannot make a commitment on what more we might do in relation to the Auditor General's recommendation, I acknowledge that it is worthy of further consideration.

The Convener: Thank you for all your responses, cabinet secretary. We have run out of time, unfortunately. I thank you and your officials for giving the committee your time this morning.

At our next meeting, on 17 May, the Minister for Mental Wellbeing and Social Care will provide the committee with an update on the social care sector in Scotland. That follows the publication of Audit Scotland's social care briefing on 27 January and the evidence that the committee heard from social care stakeholders on 22 February.

11:02

Meeting continued in private until 11:30.

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