OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 11 August 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
19th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Richard McCallum (Scottish Government)
Elinor Mitchell (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 11 August 2020

[The Convener opened the meeting at 10:00]

Pre-Budget Scrutiny (2021-22)

The Convener (Lewis Macdonald): Good morning and welcome to the 19th meeting in 2020 of the Health and Sport Committee.

The first item on our agenda is an evidence session on the 2021-22 budget. The committee's scrutiny approach reflects the approach that was recommended by the budget process review group, which entails addressing budget implications throughout the year and bringing the information together to inform a pre-budget report for consideration by the Cabinet Secretary for Health and Sport.

This year, the committee has agreed to undertake pre-budget scrutiny of the 2021-22 budget while considering the impact of Covid-19 on the health and social care 2020-21 settlement. We intend to take evidence from relevant bodies in August and September, before hearing from the cabinet secretary.

At this first in the series of meetings, we will hear from senior leaders in the Scottish Government. I am delighted to welcome Elinor Mitchell, who is the interim director general of health and social care, and Richard McCallum, who is the interim director of health finance and governance.

As you know, we will hear from members in turn, with questions that have been allocated in advance. I will start.

What additional sums do you expect to be allocated to the health and social care budget over and above the £620 million that was identified in the summer budget revision? Could both witnesses respond?

Elinor Mitchell (Scottish Government): Good morning. So far, health and social care consequentials amount to £1.3 billion. In addition to that, we expect additional consequentials as a result of the £3 billion winter-planning moneys that the United Kingdom Government recently announced. I will pass over to my colleague to provide the details.

The Convener: That is helpful. Is the £620 million part of the £1.3 billion consequentials?

Elinor Mitchell: That is correct.

The Convener: I call Richard McCallum.

[*Temporary loss of sound.*]

The Convener: Can we have sound for Richard McCallum? Perhaps we can come back to him in a moment, if he is not able to connect himself from his end. It might be that he needs to unmute the microphone on his iPad.

Richard McCallum (Scottish Government): Can you hear me now?

The Convener: Yes.

Richard McCallum: I will pick up from Elinor Mitchell's points. The summer budget revision was a point-in-time allocation of £620 million. Since then, we have had confirmed funding of £1.3 billion. The big difference between the £620 million and the £1.3 billion figures relates to personal protective equipment consequentials of £466 million, which have now been confirmed. In addition to the £1.3 billion, we have also had confirmation that there will be an additional chunk of money for PPE, but that has not yet been added to our Barnett scorecard.

As members will likely be aware, there was an announcement of £3 billion of winter funding for England, so we expect consequentials of about £250 million from that, over and above the £1.3 billion that has been confirmed.

That will all be set out in the next month or two in the autumn budget revision, which will contain the more up-to-date detail that was included in the summer budget revision.

The Convener: How have decisions been made on allocation of the additional funding to different parts of the health service?

Elinor Mitchell: I will outline two processes that we work through under our governance arrangements. Within the Scottish Government, we set up a planning and assurance group consisting of senior officials, including clinical advisers and clinical leads. We have met very regularly—weekly, and sometimes twice weekly—and have taken decisions on prioritisation of the funding that was coming through to us. That was in addition to the on-going close work that we did with national health service boards, integration authorities, local government and the Convention of Scottish Local Authorities.

The premise that we were working on was the commitment that was given by the Cabinet Secretary for Health and Sport that we would meet all reasonable costs in relation to additional services that were required. The planning and assurance group regularly considered bids that were coming in, what required to be done and how the allocations should be taken forward.

There is a process—which Richard McCallum can outline—through which we then release funding to health boards and local authorities and, through them, to the integration authorities, after their funding bids have come in. Richard will give more detail.

Richard McCallum: In answer to your initial question, convener, the key thing when it comes to all the funding decisions is that we are making them on the basis of the best data and evidence that we have available. All the funding decisions that we made on the initial mobilisation relating to the capacity that was required in the system were supported by the data and evidence that were available at the time. That continues to be our approach.

As Elinor Mitchell said, we have a governance process that ensures that all spend is the subject of scrutiny and approval by officials. Furthermore, any spend over £1 million that was not agreed as part of the initial budget that we discussed with the committee back in February would need the approval of both the Cabinet Secretary for Health and Sport and the Cabinet Secretary for Finance. That is the approach that we have taken with all spend.

For health boards and integration joint boards, that process has been in place from the start of the pandemic response. We asked boards to submit financial returns, initially weekly, to highlight the costs that they were incurring, and so that we could approve health boards' funding requests. Likewise, that has needed ministerial approval. We will, subsequently, once we have completed a full review of the costs in the first quarter, allocate funding to the health boards and IJBs on the basis of costs that have been set out by boards.

The Convener: Can Elinor Mitchell say whether the additional sums that have been allocated to the health service thus far have been sufficient to address the response to the coronavirus epidemic?

Elinor Mitchell: As far as we know, they have. As Richard McCallum said, we went out to health boards and integration authorities at the start and asked them to estimate their additional cost requirements. We are in the process of reviewing their returns. We have committed to funding those requirements fully. Some money has been allocated, and additional moneys will be allocated according to the process that Richard outlined. As far as we are aware from the information that we have, we are fully funding the requirements of the integration authorities and the health boards, at this time.

George Adam (Paisley) (SNP): Good morning. You have already spoken about the £1.3 billion of consequentials that are coming to the Scottish Government from Westminster. Have any commitments been made down south on health and the Covid crisis for which we have not received money, or have we received absolutely everything in consequentials from what is being spent down south?

Elinor Mitchell: Richard McCallum is probably closer to the details on that. My understanding is that, as with all consequentials arrangements, moneys are announced from a UK Government perspective, then we get our allocated share through the Barnett arrangements. The money that we have received so far reflects what has been spent in England. Richard might have more detail.

Richard McCallum: There are two things to point out. First, as Elinor said, when there is an allocation from Her Majesty's Treasury to the Department of Health and Social Care, consequentials should, by extension, naturally flow from that. We have therefore had regular dialogue with the health department and the Treasury to ensure that that process is in place and that it is working as it needs to. That dialogue has been effective; funding has been passed on.

Secondly, in some areas of spend more of a four-nations approach has been taken—in relation to test and protect and some of the testing centres, for example. Therefore, the funding flows do not necessarily all follow in exactly the same way. The costs for a testing centre will be incurred by the UK Government, therefore moneys that are associated with that would not be passed on to the Scottish Government as consequentials.

George Adam: With that in mind, has the Scottish Government had flexibility, within the arrangements, to move money in the health budget to ensure that what it wants to do is done?

Richard McCallum: With all consequentials—health, which we have been talking about, or otherwise—it is ultimately for Scottish ministers to decide how best to use them and how they are allocated. There is flexibility to do that. That is what we would expect and that is what we have put in place.

When spending is done on a four-nations basis, such as the testing spend that I mentioned, there is not the same flexibility. In relation to consequentials, we normally expect that flexibility to be there so that the Scottish Government can use the money as it thinks necessary.

The Convener: George Adam.

George Adam: I am sorry, convener—I am a wee bit out of practice, as this is my first meeting since the recess. I should have said that that was my final question.

The Convener: Thank you. I will move on to David Stewart.

David Stewart (Highlands and Islands) (Lab): Good morning, all. I will ask specifically about health board budgets. How will the Covid-19 pandemic impact on the ability of boards—[*Temporary loss of sound*.]

The Convener: I think that that was a question about breaking even.

10:15

Elinor Mitchell: I did not hear the full question. Was it about break-evens over the whole period?

David Stewart: Yes.

Elinor Mitchell: Obviously, health boards in Scotland were put on an emergency footing at the beginning of the Covid outbreak, in recognition of the particular circumstances that were facing them. That meant that routine financial planning and development of savings plans were temporarily paused in the face of the immediate requirement to respond to Covid-19. As you can understand, that was absolutely the right thing to do. Now, as part of the remobilisation work that we are doing, we are turning to the three-year plans.

As a matter of routine, health boards are required to submit their updated financial forecasts as part of the quarter 1 review process. We will see some more submissions pretty soon—from memory, I think that it will be on 14 August. At that point, we will consider boards' trajectories and will be able to see what they are looking at this year and what their thoughts are about future years, then we will take stock of the situation. Richard might have more detail, to add to that.

Richard McCallum: I support the comments that Elinor Mitchell has made. Our starting point will always be that boards should deliver in line with the plans that they set out at the start of the financial year. As the committee will recall, for 10 of the territorial boards, the plans involve delivering a balanced outturn. For the four boards that were escalated for financial reasons, the plans require delivery of a financial trajectory that improves on overspends in previous years. As Elinor said, we expect that all additional costs related to Covid will be funded, so we expect boards to continue to deliver the trajectories that we have set out.

We need to see just what the impact will be of our having gone on to an emergency footing, both in the immediate future and in the slightly longer term, over the next two to three years. As well as the allocation of funding to support the first quarter's costs, we will be looking to set a revised budget for boards for the rest of the financial year, and to ensure that they deliver in line with the plans. We also want to consider opportunities that might result from Covid—for example, efficiencies might have presented themselves that might help boards that need to return to financial balance to make progress on that.

David Stewart: Do you have concerns about the financial sustainability of any boards?

Elinor Mitchell: Richard McCallum is closer than I am to the issue, but my understanding is that, largely, boards' variances from financial plans are related to Covid. The impact of the outbreak has varied across the country; some boards are spending more than others on what they need to do. A look at that issue will be part of the wider assessment that we will do when the quarter 1 returns come in. However, at the moment, I have no particular concerns about any health board. As I said, increases in spend are largely because of Covid.

Richard McCallum: We have spoken before about the four boards that were, pre-Covid, escalated for financial reasons. In the past month we have focused on the impact on those boards, and that focus will continue for the remainder of this year, into the next financial year and beyond.

As I said, we are reviewing budgets and plans for the remainder of this year. The information that we will get back from our boards on 14 August will show us what their financial trajectories look like for the rest of this year. That will inform our thinking about whether those boards require further interventions or support.

As Elinor Mitchell said, we have a plan for all boards to review the costs relating to Covid, and we are confident that we have the funding to support the additional challenges that have emerged as a result of the crisis.

David Stewart: That is all well and good, but the reality is that some boards constantly require brokerage just to break even. The figures from January 2020 show that five boards—including NHS Highland in my region—required additional support of almost £50 million. Is there a real problem with brokerage? Does that indicate to you that those boards are not financially sustainable?

Elinor Mitchell: I will pass that one straight to Richard McCallum, if that is all right.

Richard McCallum: To answer the question regarding those boards, it will give us confidence if we see that they are progressing along the plans that they have in place to break even. We have a three-year trajectory to enable the four boards that are currently in that position to return to financial balance. With regard to confidence and sustainability, that will be clear provided that they can deliver in line with those plans.

To support that view and provide some confidence, I point out that, in the previous financial year 2018-19, just over £70 million in brokerage support was provided, whereas in 2019-20 the amount for those four boards came down to £45 million.

While those boards have their challenges—[*Inaudible*.]—we are seeing the trajectory improve, and that will give us the confidence to ensure that they are on course to deliver financial sustainability moving forward.

David Stewart: This is my final question. I move on to the pressing problem of the repairs backlog, which is obviously a capital issue. As the witnesses will know, in 2017—the last year for which I could see figures—there was an outstanding backlog of £900 million of repairs, of which 10 per cent were designated as high risk and 35 per cent as significant risk. With Covid, a backlog of repairs could impact on the effectiveness of infection control and cleaning. What assessment have you made of the chronic problem of the repairs backlog? What capital investment do boards need to resolve that pressing problem?

Richard McCallum: I do not have the exact figure on the maintenance backlog to hand, but the levels are in a similar range to the figures that you described from a couple of years ago: approximately £900 million.

I will make a couple of specific points in response to your question. First, some of the cost relates to new investment that is going into the system, particularly in relation to the elective centres and the Baird family hospital and ANCHOR—Aberdeen and north centre of haematology, oncology and radiotherapy—centre project in Aberdeen. Those facilities will address some of the immediate concerns in the regions where they are coming on stream—there is an elective centre in Highland, for example.

Secondly, we have a programme of backlog maintenance reduction, and I would be happy to provide some more details on the approach that we are taking to tackle the backlog challenge that we face.

The Convener: Thank you—I am sure that that would be welcome.

We move to questions from Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning, everybody. Our briefing paper notes that the summer budget revision identifies an additional £164.3 million of spending on health interventions, but there is no further detail about what those specific measures relate to.

I know that health interventions are wide ranging—for example, that would include research. If we focus on coronavirus as our number 1 priority, I am thinking about what we would need to do to support rehabilitation, flu vaccination, test and protect and information technology requirements across the whole country for general practitioners as well as for schools.

I am interested in hearing a wee bit more detail about the specific health interventions that have been supported with the additional allocation of £164.3 million.

Elinor Mitchell: It is fair to say that the scale of the challenges across the country and the level of uncertainty that we have faced going into the pandemic have been quite extraordinary, and the way the front-line health and care services and my colleagues in the strategic family and beyond have stepped up and responded has been absolutely phenomenal.

The scale of change that we have seen in what we have delivered has also been pretty remarkable. For example, we have set up community hubs across Scotland in relation to supporting Covid. That has been phenomenally successful in making sure that the GP community has been able to continue to work and to focus on the work that it needs to do with the wider community, making sure that Covid-positive patients have been treated through a separate pathway.

As you said, we set up the test and protect system and service from almost a standing start, moving from having a lack of capacity in hospitals to each health board having capacity to undertake tests. We have rolled out the near me programme and the hospital at home programme and we have significantly reduced delayed discharge. We have shielded 150,000 clinically vulnerable people. We have mobilised the NHS Louisa Jordan hospital in order to increase capacity as needed, and we have scaled up all the hospitals in order to respond to the degree of uncertainty. We were not sure what was going to happen, so we invested significantly in ventilators and additional equipment just in case we needed it. In the event, we did not need it, but a significant amount of planning resource went in to make sure that the NHS was very well prepared to deal with what could have hit us.

I could go on and on about the number of changes that we have made and the things that we have done. It has been really quite remarkable. If it would be helpful, I am more than happy to list those things and send the committee a more detailed note for further perusal, or to talk about any aspect that I have mentioned.

The Convener: Thank you. Again, a note to the committee would certainly be welcome.

Emma Harper: I agree that the response to Covid from everyone, including the national health service, essential workers and volunteers, has been absolutely phenomenal. That absolutely needs to be sung from the rafters. It would be useful to have a list of the wider interventions, because they are very broad. Obviously, we have had to take a wide-ranging approach in order to tackle all aspects of the pandemic.

I am interested in the widening of access to flu vaccination to cover all primary school children up to 12 years old, as the nasal vaccine works for kids as well.

I wonder whether you are projecting that the amount that has been spent on those wide-ranging health interventions is sufficient. Are you projecting that the demands that have been created by the pandemic will mean that more money needs to be directed elsewhere in order to continue to tackle it?

Elinor Mitchell: We are planning to do the single biggest ever vaccination programme for seasonal flu. In addition to extending flu vaccination to the group that you mentioned, we are extending the age group downwards to cover the over-55s. We expect that the programme will cover about 2.5 million people. We are planning to roll out that programme, which will be significant, between now and the end of December, and we are working closely with the health boards across Scotland to make that happen.

That is, of course, in advance of any plan for a Covid vaccination programme, which will take place as and when a vaccine becomes available for use. That would be a significant and major undertaking, which is why we are working very hard on it with Public Health Scotland and beyond in order to ensure that one of the legacies is a world-class public health response system. We are determined to deliver that for Scotland.

We have scaled up the test and protect programme that we have in place and we are now able to deliver over 13,000 tests a day in Scottish labs as well as the 22,000 that are delivered through the UK lab in Glasgow. We have plans to scale that up if we need to.

As committee members know, there is an outbreak in Aberdeen at the moment. We have been working hard to respond to that, which we have done appropriately using arrangements across the various health boards, but we need to scale up the number of contact tracers.

There are a number of things that we continue to have to work on and invest in to ensure that we are responding appropriately to the virus as it continues to be with us.

10:30

We are also, with health boards, investing time, energy and attention on second and subsequent wave planning to ensure that we are as ready as we possibly can be. We are looking at a range of scenarios, including resurgence of the virus, outbreaks, second and subsequent waves, concurrent risks around flu, and of course Brexit. We are working hard across the board with a number of partners—not just health boards and local authorities—to ensure that we are as prepared as we can be for what comes over the horizon.

Richard McCallum might want to pick up on the wider financial aspects of that.

The Convener: Before I bring Richard in, can I just check something, Elinor? Did I hear you mention 13,000 tests in Scottish labs plus 22,000, or 30,000 plus 22,000, and is that a daily figure for testing capacity?

Elinor Mitchell: I said 13,000, and it is a daily figure.

Richard McCallum: I just have a couple of brief points, picking up on what Elinor Mitchell said and going back to the initial question about the £164 million of spending on health interventions. The costs associated with those figures will be more than that—that was a point-in-time estimate. As we have outlined, we are doing work to ensure that all costs forecasts for the various programmes that Elinor has set out have robust financial governance behind them and are subject to the appropriate budgetary challenge and control. If we take the test and protect programme as an example, we have built up funding streams to support each strand of the programme—test, trace, isolate and support. I assure the committee that we have got robust financial processes in place to support the range of programmes that Elinor mentioned.

Miles Briggs (Lothian) (Con): I want to ask a number of questions about delayed discharge. Back in 2015, the Scottish Government set a target of abolishing delayed discharge. We know that beds have been bought up during the Covid crisis. Do you know what resources were allocated to that, and why were those resources not previously made available to reduce or abolish delayed discharge?

Elinor Mitchell: I will ask Richard McCallum to comment on the financials around that.

The work that we have done since the beginning of the pandemic to significantly reduce the number of delays in hospital has been quite transformational. That work is very much based on the principles around the “discharge to assess” model and the “home first” approach, which are

some of the main lessons that we have taken from this.

One of the factors that has made this such a success is the single focus and desire of all parties involved to ensure that people were moved out of a hospital environment into alternative accommodation as swiftly and safely as possible. The numbers have gone down significantly, although they have started to rise as hospital admissions have increased. I think that that work is testament to the determination and ambition of all the parties who were involved in it.

Richard McCallum: I just have a couple of things to add to that. As I have mentioned, boards and integration authorities have submitted cost estimates to us for the first quarter. An initial estimate was a figure of around £50 million that was allocated to support the reduction of delayed discharge. We are working with the health boards and IJBs through the quarter 1 reviews, which we have already mentioned, to review those costs, but that is the figure that we have been given as the estimate for the first quarter to support that reduction.

Miles Briggs: Thank you for that information. Is it fair to draw a conclusion that, previously, resources were not available to drive down delayed discharge and it is only because of that additional resource that has now come online that it has been possible to purchase these beds? There will be increasing levels of delayed discharge because we are seeing capacity return but will we try to learn these lessons to stop people continuously experiencing delayed discharge?

Elinor Mitchell: Part of the answer has to be the way in which resources are distributed across the system. The cost of providing long-stay accommodation in the NHS is more than the cost of providing care-at-home services or a bed in a care home, so the issue is about how the money is distributed across the system.

One thing that has come about through this pandemic is a greater understanding of how people, information and data flow through the system, and an understanding of how we can best support people at home or in a homely environment, so there are many lessons that we can learn.

On funding, as Richard McCallum has said, the initial tranche of £50 million was allocated to health and social care partnerships to support them around delayed discharge and other things and further funding will follow from that.

It is as much a matter of the distribution of resources as it is the quantum of resource.

Miles Briggs: To push this point home, it is quite clear that we were not funding the policy to abolish delayed discharge; we have only been able to see that reduction happening because of that additional £50 million. Is that your view as well? If we are going to properly fund social care, it is important to understand that, potentially, we were not making those beds available previously.

Elinor Mitchell: The benefit of hindsight is an astonishing thing, isn't it? We have learned all sorts of lessons as we have gone through this process. Before we went into this, when I was director of primary community health—I think that that was the title; I cannot remember what the name of the directorate was at the time—we were working very hard with all the health and social care partnerships to look at the barriers to reducing the delays. Funding was one issue, but it was but one of many issues that were raised. There are also cultural issues—for example, I mentioned the "discharge to assess" programme, which was implemented in some parts of Scotland but not in all parts of Scotland because of how hospital systems were run and how discharge procedures were organised.

There are a number of factors. We have done a lengthy piece of work, which involved speaking to all 31 health and social care partnerships about lessons learned. I am more than happy to share that work with the committee if that would be helpful. However, as I said at the start, the most significant element was the joint commitment and shared sense of purpose that saw everyone working towards that shared common goal of making sure that people could be released out of hospital into their home or a homely environment.

Miles Briggs: It is important that we learn the lesson if we are going to carry the policy forward. However, I want to return specifically to my area. Historically, delayed discharge has been a significant problem in the Edinburgh IJB. You said at the beginning that IJBs have been fully funded. Why, in that case, is my Edinburgh IJB looking to make £36 million of cuts to services? Given the problem that we have here in the capital, how will that help to drive forward the abolition of delayed discharge for my constituents? What is happening in the Scottish Government to enable it to understand that IJBs are in an impossible situation?

Elinor Mitchell: I will pass your question about the detail of funding on to my colleague Richard McCallum. We have been working extensively with all health and social care partnerships to understand the funding and budgetary issues that they face and to ensure that all the additional funding—the £811 million that the Scottish Government has allocated to social care—is passed on appropriately.

Richard McCallum can pick up on your specific points about the Edinburgh partnership and the funding issues there.

Richard McCallum: In 2020-21, £23.6 million of funding was allocated to the Edinburgh IJB, which represented an increase in its budget. That support was provided to deliver the services that have been set out. In addition, the Edinburgh IJB received a share of the £50 million that we mentioned previously, which equates to approximately £4.1 million.

We have taken steps to fund the Edinburgh IJB, as we have done with all partnerships. The funding is allocated via health boards and IJBs. On the particulars of the savings plans, the boards and IJBs need to work through the plans that they have in place, but that should be done in a way that ensures delivery of the services that are expected and have been set out.

We are working closely with the Edinburgh IJB on a range of matters to ensure that support is in place. We have provided some practical support, in particular by looking at how the care-at-home model that is in place in Edinburgh can be strengthened and operated differently, given the range of providers. The Edinburgh IJB needs to take some specific actions, and we are working closely with it on that.

The Convener: Before I bring in another colleague, I have a question for Elinor Mitchell. Overall, how has the model of integrated health and care provision functioned during the pandemic? Has it brought new challenges or offered new solutions? Has the experience of the pandemic highlighted any areas for improvement in the structures that are in place for making decisions on the allocation of resources in and around IJBs?

Elinor Mitchell: From my perspective, I do not think that we could have delivered what we have done without integration or living and working in an integrated health and social care world. The chief officers, to whom I speak regularly, certainly share my view that we could not have achieved what we have achieved without integration.

The close partnership arrangements that we have built up in recent years between managers and professionals both within health and across health and social care have been particularly valuable. We can look at the work on care homes, for example—I am sure that we will come on to discuss care homes later. Having local care managers sitting within health and social care partnerships and working closely across and between social care and health boards has proved to be invaluable as we strive to put our arms around the care home sector and support it effectively.

With regard to resourcing, the ability to mobilise a whole system of resources that includes people as well as money has made a real difference to our ability to respond to these very challenging times.

Sandra White (Glasgow Kelvin) (SNP): Good morning, everyone. First, I want to pick up on the convener's previous question, which is important because of the situation with integration. In some areas, unfortunately, integration has not been fully rolled out, but it is desperately needed in order to work alongside the Convention of Scottish Local Authorities to ensure that local councils have capacity available in their care homes. Is it fair to say that working more closely together in that way would be much more helpful with regard to delayed discharge? Sometimes, the barrier in that respect is that there are not enough care home places.

10:45

Elinor Mitchell: I talk to chief officers regularly and they play a bridging role between local authorities and health boards. They are clear about their important role in bridging the gap and bringing together mobilisation planning between what local authorities are planning to do in relation to social care support, for example, and what health boards are planning to do in their work on frail elderly people. That has been fundamental to the system.

The integration and the legislation to deliver integrated health and care services are still relatively new, and we are still working through some of the issues. At the end of last year, we were considering joint accountability arrangements for health and social care partnerships. For me and many others, the pandemic has shown us that integration can work successfully. The more integrated ways of working we can deliver, the better for the people of Scotland.

Sandra White: Thank you for allowing me to come in with that question, convener.

I now have some questions on PPE. You possibly answered my first question when you mentioned the £466 million, with further moneys coming forward—if you have already answered it, you can tell me. I do not know whether the figures that you gave us earlier regarding the Scottish Government's spend on PPE have been updated. Are they up to date? Secondly, do you have updated figures on the Barnett consequentials that have been received as a result of spending on PPE? Finally, were sufficient funds available to purchase the necessary PPE?

Richard McCallum: There are a few things for me to clarify. The £466 million relates to consequentials that we have received. As I said,

we expect to receive some more consequentials relating to PPE. So far this year, we have spent about £200 million on PPE in the first two or three months of the pandemic response, and we approved a further £114 million in the past month or so to take forward further spend. We expect to acquire spend of about another £300 million for PPE, as a minimum, to see us over the winter, although that is dependent on a few modelling scenarios that we are working through—we are continuing to do that.

The other strand that we are picking up is what we will require by way of a PPE stockpile. There are a few components to that. As you identified, the £466 million for PPE will be used to support the PPE purchases that we need to make.

The answer to the question about whether sufficient funds were available to purchase the necessary PPE is yes. We made an early commitment to NHS National Services Scotland, which procures PPE not just on behalf of health boards but on behalf of social care providers. At an early point in the process, we agreed funding for NSS so that it could take forward the requirements for PPE.

The key point is that NSS has never reached a point where we have run out of any stock. We have always had the stock available, even at the height of the first wave. The plan now is to ensure that, for future waves, and particularly looking ahead to winter, we have the stockpile in place that will give us and health and social care colleagues the confidence that PPE is available as needed.

Sandra White: Thank you. When will the committee get further information and up-to-date figures on the moneys that are coming forward? We are told that there will be allocation of consequentials, but is there a time lag between the announcement and the money being given to the Scottish Government? If so, what do you do?

Richard McCallum: On your first point, we absolutely can provide further detail about our PPE projections and plans and our spending plans.

On the second point, there is a time lag. From our perspective, the key thing is to ensure that there are good lines of communication and discussion with HM Treasury and the Department of Health and Social Care. Barnett consequentials are added only at certain times, but we have discussions with the department and we knew that there was a need to purchase the PPE—quite simply, this was an area that we needed to prioritise in the early part of the pandemic response.

Although there is a bit of a delay in getting full notification, we made decisions early to ensure that the funding was available to allow NHS National Services Scotland to make the purchases that were required, albeit that it had some existing stock available.

Sandra White: Are you saying that the time lag did not affect your ability to purchase PPE? Was the money there in the budget so that you could afford the PPE, or have you had to take money from other parts of the health budget before you see the money?

Richard McCallum: Because, in a sense, the costs will all be charged to the 2020-21 financial year—I will try not to go into the technical accounting stuff—and because we knew that the funding would be coming, we were able to take decisions with NSS with some confidence and certainty that the costs that it was incurring would be funded by the Scottish Government.

In relation to your other point, a strength of our response is that NSS is a national supplier for items of stock for all our health boards, so its existing supply routes allowed us to respond quickly. One of the strengths of our approach has been that one body purchases on behalf of NHS Scotland, which has allowed us to use NSS's existing good supply routes to respond as we needed to do.

Sandra White: A Scottish Government report that came out on 5 August said that 17 million items of PPE were distributed across Scotland by NHS National Services Scotland. The response was pretty speedy. As well as using NSS, were you able to procure and manufacture locally? Obviously, manufacturing is done internationally. To what extent did you and the UK Government take a four-nations approach to purchasing PPE? Were there economies of scale in that respect?

Richard McCallum: We have had good relations with the other nations throughout, on PPE. We have kept up lines of communication with colleagues in England, Wales and Northern Ireland so that we understand what the various countries are doing by way of procurement. We do not want to get into a position of trading off against each other, certainly with suppliers.

Initially, the Department of Health and Social Care was quite keen to secure economies of scale and purchase on behalf of all four nations, but because we had good supply routes through NSS, our approach—I think that the feeling in the other countries was the same—was that, rather than buying items together, as one, we should take forward our own approaches to buying stock while working on the basis of a mutual aid model so that, if Wales, Northern Ireland or England was running low on an item, we would provide it, and when items were available elsewhere they would be provided back to us. For example, we provided

Wales with 1.2 million type IIR masks, and subsequently, when Wales received its stock order, items were returned to us. The mutual aid model has worked relatively effectively over the past few weeks and months.

Sandra White: I am reminded that some of the PPE that England acquired was, unfortunately, absolutely no good. It is good that, as well as having a four-nations approach, the three other countries did their own thing.

Do you want this to be my final question, convener?

The Convener: Yes.

Sandra White: I could put three questions together, but I will not do that, convener.

We have now built up stocks and increased the volume of PPE—I thank Ivan McKee, the Minister for Trade, Investment and Innovation, for going out and getting stocks, too. What are the expected on-going costs of maintaining adequate stocks of PPE?

Elinor Mitchell: I wanted to come in on a slightly different point. Richard McCallum might say more about the on-going costs; we are still working to identify our PPE needs, given the significant and extensive remobilisation planning that we are undertaking.

I just wanted to pay tribute to the fantastic and phenomenal collaborative effort that went into ensuring that we had sufficient and appropriate PPE supplies during the pandemic. Richard McCallum has talked about the four-nations approach, which was successful, but relatively early on we also pursued a make-and-buy strategy and we had more than 2,000 responses from Scottish businesses that wanted to support health in that way, many of which are continuing to provide support. It is important to recognise the collaborative effort—not just in the Scottish public sector—through which we have distributed more than 350 million items so far across the acute sector, primary care and social care. It was a phenomenal effort, and everyone in not just the public sector but the private sector pulled together.

Richard McCallum: The buy-and-make, two-pronged approach is central to our strategy. Ms White asked about the long-term approach to stockpiling; the buy-and-make approach, using the likes of Don & Low for fabric for PPE and Alpha Solway for masks, is a key part of our strategy for the stockpile.

At the moment, our key focus is to make sure that we have an adequate stockpile for the winter and, looking ahead, 2021 and 2022. A key question is how long the virus will be with us and how long we will need to use the level of PPE that we are using at the moment; we are undertaking modelling work on that just now. A key focus for us—I have said that I will come back to the committee on the associated costs—is thinking about what stockpile will be required, as we look ahead to next year and beyond.

11:00

The Convener: Thank you. I am conscious of time, so I will move on to Brian Whittle.

Brian Whittle (South Scotland) (Con): Community hubs were mentioned earlier. Through the summer budget revision, £35 million was allocated to community hubs in response to the effects of Covid-19, specifically around trying to ease pressures on general practices and hospitals. Is there evidence of how effective the hubs have been, particularly in relation to their impact on GP patient numbers?

Elinor Mitchell: Since 23 March, we have had more than 130,000 contacts through the 111 number. Of those, just over 30,000 were advised to self-care, 90,000 were transferred to the hubs and 8,000 were triaged to 999. Previously, all those people would have either gone to their general practice or to an accident and emergency department. In that regard, the hubs have been very helpful in managing whole-system patient flow and making sure that people are getting the right care and attention when they need it.

We have not had a chance to do a formal evaluation of the hubs, although we are hoping to build the use of hubs into our patient pathways, particularly in relation to a consideration of how unscheduled care is managed and people are helped to access the right treatments from the start.

Brian Whittle: You are saying that the community hubs have been effective. Do you think that sufficient funding has been provided to support the operation of the hubs?

Elinor Mitchell: Yes, I think so. We asked health and social care partnerships to give us their estimated cost of running the hubs. Of course, the model is based on the GP out-of-hours service. We will get more information when we get the returns back and look at what people have done.

We are looking to roll out the use of hubs in our delivery of health and care services in Scotland. As hubs become part of the way in which things are done, we will have a greater understanding of their on-going running costs. I would say that they have very much been part of our success story.

Brian Whittle: Finally, I would like to understand how much longer you think the Covid-19 community hubs are expected to be operational and at what cost. I was interested to hear you mention the on-going benefits of the hub

approach. Could it spill into other areas of the NHS that are looking for efficiencies, and have lessons been learned about how we approach healthcare?

Elinor Mitchell: Yes, absolutely. There are a number of aspects to the lessons that have been learned. I guess that Covid will be with us until we have a vaccine, so we would expect to continue to run the hubs for as long as we need to. As I said previously, they have been considered a success. They fit very well with the aspirations around phase 1 of the GP contract, which is about ensuring that GPs are expert general medical practitioners, working to see a greater acuity of patients. The work of the hubs is very helpful in that regard, and they help to make use of the multidisciplinary teams in primary care and make sure that all that can possibly be done in primary and community settings is done. The hubs also build on the once for Scotland approach, which involves making sure that we are doing things as consistently as possible across Scotland.

The number of hubs has fluctuated as we have gone through the pandemic, largely related to volumes, but we are considering them with regard to the patient pathway. We are interested in that approach in terms of how we transform the delivery of unscheduled care; for example, when people turn up to A and E when there are perhaps better ways of caring for them.

David Torrance (Kirkcaldy) (SNP): Over what timescale is NHS Louisa Jordan hospital expected to be kept operative, and what care is it currently providing? Could it be used to provide a wide range of postponed, non-Covid planned healthcare that has been delayed?

Elinor Mitchell: I will pass that question to Richard McCallum.

Richard McCallum: We are looking at options for keeping NHS Louisa Jordan open for the remainder of the financial year, over the winter.

That takes us to the second part of Mr Torrance's question. NHS Louisa Jordan is a national resource. Since early July, it has been providing a range of out-patient activity, particularly in orthopaedics and plastic care for patients. That has been a pilot arrangement—primarily, NHS Lanarkshire has been using it and NHS Education Scotland has also been using it as an education hub and a safe place for training, staff development, and support in those areas. It is very much a resource that can potentially be used.

We have spoken already during this session about boards' remobilisation plans, which they are submitting to the Scottish Government. When we combine all the remobilisation plans, and look at the modelling on potential future waves, going into winter, we will be looking at the very point that David Torrance has made: how can we use NHS Louisa Jordan, not just for the areas that I have already mentioned, but, through building it up, for other purposes?

David Torrance: What are the on-going costs of running NHS Louisa Jordan, and how do they compare with those of other hospitals?

Richard McCallum: I think that the summer budget revision mentioned the cost of NHS Louisa Jordan as being £27 million. We have finalised the initial set-up costs that we have spent to get NHS Louisa Jordan kitted out and ready to be used, which we think will be about £31 million.

There is a governance and oversight board for NHS Louisa Jordan, which is undertaking a piece of work to look at the on-going running costs and what they could scale up to over the remainder of the year. I think that it is due to publish that at the end of August; I wonder whether the most helpful thing would be to provide that to the committee at the same time, so that you would have that information.

It is difficult to compare the facility to a traditional hospital, where there are all the usual fixed costs; there is not necessarily a direct read-across. I have two things to say about that. First, we have kept in close contact with colleagues in Wales and England over the Nightingale hospitals. The costs associated with NHS Louisa Jordan are very much in line with those of the Nightingale hospitals in England and Wales, and we have been sharing best practice with colleagues about that.

Secondly, I go back to the work of health facilities Scotland, a specialised body within NHS National Services Scotland, which has done a phenomenal job in taking forward the work on NHS Louisa Jordan—resourcing it and kitting it all out, at some speed. The appropriate governance and support for health facilities Scotland have ensured that we have done that in the most financially prudent way possible.

David Torrance: What preparations are under way for a potential second wave of coronavirus infection? Given the investment in NHS Louisa Jordan, can you expand on what role it will have in any potential second wave?

Elinor Mitchell: As far as planning is concerned, we have written out to the health boards and the health and social care partnerships—the resilience partnerships—to set out three potential scenarios for the impact of Covid-19, and we have asked them to come back to us with their plans for mobilisation of health and care services in those three scenarios. We have had some initial returns and we are expecting further returns.

As part of the general assessment of our preparedness that we will carry out, we will look at capacity in the acute setting, in social care services and in care homes. We will also look at the issues to do with PPE that we have discussed, vaccination programmes—for seasonal flu and, potentially, for Covid—the continued requirement for test and protect, our broader testing strategy and surveillance for testing. It is a complex process. One of the things that we have learned is that it is much easier to turn off NHS and care services than it is to restart them safely.

NHS Louisa Jordan is part of the planning process. Boards have been asked to think about how they might use that facility to help with access to services. However, account will need to be taken of the fact that it is a temporary facility.

Extensive work is under way. We are working with boards and partnerships to make sure that we are as ready as we can be for what is to come.

David Torrance: Has any additional funding been made available to support those preparations? If so, how will it be allocated?

Richard McCallum: Additional funding will be made available to health boards. I have already mentioned the £250 million of funding for winter planning. We expect further funding to be made available on top of that, which we will use to support some of the decisions that we make in relation to our response to the pandemic as we go into winter.

As part of the allocation process, we will review the remobilisation plans that we have received from health boards. We will also look at the service operational plans that boards have in place and their plans to innovate and do things in different ways. On the basis of the remobilisation plans, as I mentioned earlier, we will allocate a further tranche of funding to boards and IJBs, which they will be able to use as the basis for taking forward their winter plans. We expect to do that over the coming months—we expect to have that funding in place by the end of September so that boards can progress their plans for winter.

Alex Cole-Hamilton (Edinburgh Western) (LD): Which areas of NHS Scotland's performance have been most negatively impacted by the pandemic? What action will be taken to restore performance?

Elinor Mitchell: I should start off by saying that the chief executive of NHS Scotland, John Connaghan, is unable to attend the meeting. He would probably be better placed to answer more detailed questions about the impact on the NHS, and I would be more than happy to follow up by providing any further detail that is required, if that would be helpful.

We are currently working through with health boards which areas of performance have been most negatively impacted. With the exception of the information on cancelled operations and accident and emergency performance, we have very little detailed data. Inevitably, there has been a build-up of elective procedures as the emergency measures were implemented.

As part of the work that we have asked health boards to do within the remobilisation framework, they will assess the extent of the backlog of activity and estimate how quickly they can work through that safely, and we will plan on that basis.

We have set up an NHS mobilisation recovery group, which has a wide range of stakeholders, including the royal colleges, the unions, the care home sector and of course the boards, as well as various other representatives. That group has met twice or possibly three times, and it is meeting again on Friday. The group is working through in some detail the implications for restarting—that is about looking at the surgical capacity that we still need to protect—and how we can safely restart services and ensure that we take a clinically based approach and are doing the right thing by our patients.

11:15

Alex Cole-Hamilton: The pandemic response has seen the suspension of all non-urgent elective treatment. Has there been a significant saving as a result of that pause? Will there be any additional costs in dealing with the backlog?

Elinor Mitchell: I will hand over to my colleague Richard McCallum but, as far as I am aware, there have been no formal estimates of any savings made. The reason for that is that most of the costs of the NHS are fixed costs—premises and staff costs—which obviously we have continued to have. As I said, we are working through in some detail with each health board and associated partnership the backlog of work and what needs to be done.

Richard McCallum might want to add more financial information.

Richard McCallum: I support that point, which is absolutely right. Although some staff have moved into different roles during the pandemic response and so some of the costs associated with non-urgent elective care have not been spent in that area, they have in effect moved to supporting the Covid response. Therefore, there has not been an offset of costs as such.

On the additional costs of dealing with the backlog, as Elinor Mitchell mentioned, we will pick that up through the remobilisation plans. That is not just about the money; it will be about staff and

building up services in a safe and sustainable way. We will work through the potential costs with the health boards, which will give us clarity on the costs associated with dealing with the backlog.

Alex Cole-Hamilton: I will move on to the cost of pandemic preparedness. We know from committee evidence sessions during our Covid-19 inquiry that, despite operations such as Silver Swan, we had a significant gap in our pandemic preparedness against World Health Organization checklists, in that, while the WHO was calling for testing, we were not preparing for that. Will we need a higher level of funding for pandemic preparedness, particularly around testing, for any future pandemics? If so, what additional funding will be required?

Elinor Mitchell: I have a number of points on that. I mentioned that we are working extensively with Public Health Scotland to understand what a world-class public health response would be, given what we have learned from the pandemic. I have also mentioned the work that we have done to significantly scale up our testing capacity and the ability of our labs to process tests.

The wider issue that we want to look at is the cost of maintaining a national stockpile of PPE and other medical supplies and equipment that we might need, and not just for coronavirus or flu. Similarly, in terms of health and social care services, we want to consider the type and level of equipment and medical supplies that we may or may not need in future. Richard McCallum can give more detailed financial information on that.

Richard McCallum: The pandemic flu stockpiles have been an active part of our budget planning in each and every year prior to the Covid response. Typically, we have allocated somewhere between £10 million to £20 million for pandemic stockpiles. Looking ahead, that is inevitably going to be a key consideration of the funding that we will need to put in place for stockpiling.

At the moment, all I can say is that we certainly expect a budget for 2021-22 later, in autumn. Key parts of our considerations are what will be required for pandemic flu stocks and—as Elinor mentioned—for other items, such as PPE. We are actively considering that for this spending review period.

The Convener: What changes in service delivery have arisen from coronavirus, and which of them are likely to be retained and become permanent as and when we are beyond the coronavirus pandemic, and what are the financial implications of those changes in terms of extra spending or potential savings?

Elinor Mitchell: We have covered part of that issue before. Community hubs are likely to feature in our future as part of our reshaping of access to unscheduled care. The work that has taken place on the near me model and on digital consultations will continue. The work on promoting faster, speedier discharge from hospital, the hospital at home model and the pharmacy first approach will continue as part of a broader continuation of ensuring that as much of health and care delivery as possible can take place as close as possible to an individual's home.

Richard McCallum can speak about the finances for that.

Richard McCallum: On some of those things, we will inevitably look to take forward steps in the most financially sustainable way. There is potential for more efficiency in relation to things such as digital technology and the use of the near me model, which Elinor mentioned.

The thing that I am particularly focused on and mindful of, given that we have spoken about it before at this committee, is not so much whether things are cheaper or more expensive, but how we make those shifts in spend in the most effective way. We have talked about shifting the balance of spend and have provided evidence in the past about how we see that happening. I am quite keen to see how that can be accelerated as a result of Covid so that the funding follows the patient pathways that we will look to put in place in the most appropriate way.

For me, the issue is not necessarily simply a question of whether it is cheaper or more expensive. Instead, it is about how the funding flows and follows people in the best way to support the range of initiatives that Elinor talked about, whether those involve a digital approach, primary and community care, social care or the transfer of patients from an acute setting. We will review and take forward all of those things as part of the mobilisation work that Elinor mentioned.

The Convener: That is helpful.

Elinor Mitchell, is it possible at this stage to draw conclusions about the cost of social care? How far have those costs changed overall, and what might the projections for them be?

Elinor Mitchell: There has, of course, been an increased spend on social care. We have committed £100 million so far in relation to the increased costs. As we have said, we expect that the further information that we receive through health boards and through health and social care partnership plans will help us to understand how that work will be taken forward.

Some of those costs are very particularly related to the Covid plan. An example is the social care support fund, which ensures that workers who would normally have access only to statutory sick

pay have access to their normal hours of pay if they need to self-isolate. That is very particular to Covid. Other aspects, such as additional levels of PPE and funding for deep cleaning are also very particular to the current circumstances. All of those things need to be taken into account to enable us to understand what the on-going costs requirement in our care sector will look like post-pandemic.

Richard McCallum might want to add something to that.

Richard McCallum: Not particularly; I think that that is right. We are now taking some immediate decisions to help support social care in terms of the immediate response. What we need to do, and are doing now, is to consider what the longer-term impact is. We are probably not quite at the point at which we can say how much the costs will have impacted on social care. However, that is clearly something that we will consider in some detail in the coming months.

The Convener: I thank Elinor Mitchell and Richard McCallum for their evidence this morning, and also for the quite extensive list of further information that they have offered to let the committee have in due course. I look forward to receiving that information, which will certainly assist us and inform our on-going enquiry.

That concludes the public part of this morning's meeting. We will now move into private session, and resume on a different platform at 11:30.

11:26

Meeting continued in private until 11:38.

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