OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 15 September 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 15 September 2020

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HEALTH AND SPORT COMMITTEE
23rd Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (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:

Calum Campbell (NHS Lothian)
Susan Goldsmith (NHS Lothian)
Jane Grant (NHS Greater Glasgow and Clyde)
Mark White (NHS Greater Glasgow and Clyde)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 15 September 2020

[The Convener opened the meeting at 09:45]

Subordinate Legislation

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 11) Regulations 2020 (SSI 2020/263)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 12) Regulations 2020 (SSI 2020/271)

The Convener (Lewis Macdonald): Good morning, and welcome to the 23rd meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton.

The first agenda item is consideration of two affirmative instruments. As in previous weeks, the regulations are laid under section 94(1), which is on international travel, of the Public Health etc (Scotland) Act 2008. The provisions of the act state that such regulations are subject to the affirmative procedure. However, that procedure will not apply if the Scottish ministers consider that the regulations need to be made and brought into force urgently. In that case, they must be laid before the Scottish Parliament and will cease to have effect on the expiry of the period of 28 days beginning with the date on which the regulations were made, unless the regulations have been approved by a resolution of the Parliament before the expiry of that period. It is for the Health and Sport Committee to consider the instruments and to report to Parliament accordingly.

Today, we have an evidence session with the Cabinet Secretary for Justice and officials on the instruments. Once we have asked all our questions, I will propose that we have a single formal debate on the two motions.

I welcome to the committee Humza Yousaf, the Cabinet Secretary for Justice. He is accompanied from the Scottish Government by Rachel Sunderland, who is a deputy director in the population and migration division; Jamie MacDougall, who is a deputy director in the test and protect portfolio; and Anita Popplestone, who is the head of police complaints and scrutiny.

With the cabinet secretary's agreement, we will ask questions on both instruments together. Will you provide an update on the proposition to test passengers on arrival, particularly at airports? That is an issue that the committee has asked about previously. What developments and discussions have there been since we last discussed the matter?

The Cabinet Secretary for Justice (Humza Yousaf): Good morning, convener. I hope that you and the members of the committee are keeping well.

Airport testing was again discussed in our four-nations call last week. As you would imagine, I will have another such call later this week. The Scottish Government remains concerned that the airport testing regimes that are proposed at this stage would not be as robust as a 14-day isolation or quarantine measure.

It has been proposed that we look at testing on arrival and again on around day 8 of someone's isolation. The concern is that someone testing negative on arrival would be given false reassurance. However, getting those individuals to quarantine for at least another eight to 10 days would be extremely challenging. We know how people behave—there is some data on people's behaviours if they test negative.

The systems that have been proposed so far are not as effective as the requirement to self-isolate for 14 days, but that does not mean that we are not continuing to look at proposals from the airports. I suspect that that will be another topic of conversation on our four-nations call.

Emma Harper (South Scotland) (SNP): Are there particular reasons for divergence in the four-nations approach or specific circumstances in which that would be required? For instance, would Scotland exempt some countries when Wales would not?

Humza Yousaf: Ultimately, the reasons would pertain to individual country data. The regulations that we are discussing this week are a good example of that. Scotland removed Greece from its exempt country list unilaterally. At that point, the other nations had not removed Greece or any of the Greek islands, but they have now removed some of the islands from their lists.

When the regulations came into force, we took that decision because Public Health Scotland data, rather than the joint biosecurity centre data or the Public Health England risk assessment, showed a worrying level of imported cases: the number of positive cases that were linked to travel from Greece was the second highest, just behind Spain. The week after those regulations came into force, Greece overtook Spain, and, in the numbers that I have in front of me, Greece continues to be the country that gives us the most concern on the importation of cases.

Alignment is important, and when we can do that we will—we tend to align in the majority of cases. Equally, there is an understanding on the four-nations calls that each country will make decisions that are based on the interests of its own country, population and—[*Inaudible.*]

The Convener: Thank you. I think that Emma Harper has the answers that she wanted. I will move on to Brian Whittle.

Brian Whittle (South Scotland) (Con): Can you clarify whether the Scottish Government is receiving different advice, or whether it has set different criteria, as to which countries to exempt?

Humza Yousaf: I may have misheard the last part of Brian Whittle's question, but I think that I have the gist of it.

As I said to Emma Harper, some data is shared between the four nations, including the joint biosecurity centre data and the Public Health England country assessment. In addition, each country looks at its own data individually—I look at Public Health Scotland data on the transmission of the virus coming into the country. A range of data is used, some of which is shared between the four nations and some of which is specific to Scotland or England.

The decision that was taken on Greece is a demonstration of that. Scotland took the decision to remove Greece from its exemption list. Following that, Wales removed a number of Greek islands from its list and the UK and Northern Irish Governments then decided to do the same, but some of the islands differ from those that Wales removed from its list. Wales now has an expanded list of islands.

The decisions that are taken depend on the data that Governments have in relation to their own countries as well as the shared data. I hope that that clarifies it.

Brian Whittle: What is the relationship with other countries around Europe and further afield regarding the data that we gather from them? What are their reflections on how we are dealing with their issues?

Humza Yousaf: Ultimately, we have to take decisions on public health grounds. I understand that there can be concerns about diplomatic relations and that countries might be upset by the decisions that we take, but as long as we can justify our decisions—I am confident that we can—and explain the reasons and rationale for a particular decision, on public health grounds, we hope that other Governments will understand that our decisions have been made on no basis other than public health.

In some respects, that is quite liberating, as it means that we do not have to think too much about the politics or other matters that might often be part of our considerations. Decisions are made purely on public health grounds.

It would be wrong to suggest that some Governments are not upset—[*Inaudible*.] We have the consular corps here, in Edinburgh, and in Scotland more widely, and we are always happy to engage and explain the reasons for certain decisions.

The Convener: We move to items 2 and 3, which are the formal debates on the affirmative instruments on which we have just taken evidence. Are members content to have a single debate that covers both instruments? I see that you are. Thank you. In the formal debate, members have the opportunity to contribute to the debate but not to ask further questions.

I ask the minister to open the debate and to move motions S5M-22576 and S5M-22619.

Humza Yousaf: As always, convener, given that you have a packed agenda, and given that I have answered questions on the instruments, I am happy to waive my right to speak in the debate.

I move,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 11) Regulations 2020 (SSI 2020/263) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 12) Regulations 2020 (SSI 2020/271) be approved.

The Convener: Before I put the question on the motions, does any member want to contribute to the debate?

Brian Whittle: I know that we are tight for time, so I did not want to press the cabinet secretary on the matter, but at some point I would like us to explore how other countries gather data and how that is fed into our decision making, because I do not think that there is a consistent approach across other countries. That is probably for another time, but I would like to discuss it with the cabinet secretary at some point.

The Convener: Thank you. As no other members want to contribute, I ask the cabinet secretary to respond briefly.

Humza Yousaf: I will just say that I am more than happy to have that discussion with Brian Whittle at any point. You have pressed me previously, convener, about Public Health Scotland publishing the data on imported cases, and I am pleased to say that it will do that from 23 September. That will give the committee more detail on some of the data that we use when we make our decisions.

I should also say to Brian Whittle that the data that we use when we make decisions is owned by the United Kingdom Government. The Scottish Government and the Welsh Government have written to the UK Government in strong terms to suggest that the data be released. We do not own the data. Any influence that the member can bring to bear in that regard would be greatly appreciated. On our most recent four-nations call, I think that the UK Government understood the strength of feeling on the part of the Scottish and Welsh Governments about the release of the data, so I hope that we can get to a position, relatively soon, in which the data that we use to make decisions on four-nations basis can enter the public domain in some shape or form.

The Convener: That concludes the debate on the motions. I will put a single question on them. The question is, that motions S5M-22576 and S5M-22619 be agreed to.

Motions agreed to,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 11) Regulations 2020 (SSI 2020/263) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 12) Regulations 2020 (SSI 2020/271) be approved.

The Convener: We will report to Parliament accordingly. I thank the cabinet secretary and his officials for attending.

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2020 (SSI 2020/258)

The Convener: The fourth item on the agenda is consideration of a negative instrument. As members have no comments on the instrument, does the committee agree that we should make no recommendations in relation to it?

Members *indicated agreement*.

Pre-Budget Scrutiny 2021-22

10:01

The Convener: Our next agenda item is pre-budget scrutiny as part of our on-going process of scrutinising the budget. As we have done for a number of years, we are scrutinising the budget for the next financial year, which is 2021-22. However, in this unique and very different year, we are also considering the impact of Covid-19 on the Scottish Government's health and social care budget for the current financial year and the impact on the bodies that are funded and supported by that budget. We will hear from a number of relevant bodies before we hear from the Cabinet Secretary for Health and Sport. In this meeting, which is the fourth in the series, we will hear from two panels of witnesses: first, from NHS Greater Glasgow and Clyde, and, secondly, from NHS Lothian.

From NHS Greater Glasgow and Clyde, I welcome Jane Grant, the chief executive, and Mark White, director of finance. As is the usual practice in online or virtual meetings, we will ask questions in a pre-arranged order. I will start with the first question before going to each colleague in turn to ask questions and inviting the witnesses to respond.

I remind colleagues that we will have two separate evidence sessions this morning; therefore, I encourage members to make their questions succinct and to combine questions when that is possible and convenient. I also ask for answers to be succinct, to allow us to make good progress through the range of issues that we want to consider.

My question is for Jane Grant and Mark White. In relation to the current financial year, is it your expectation that additional costs resulting from Covid-19 will be offset by reductions in expenditure elsewhere? If not, what additional costs do you anticipate in the current financial year and to what extent do you expect the Scottish Government to provide funding to fill that gap?

Jane Grant (NHS Greater Glasgow and Clyde): Good morning. I will start, and Mark White can perhaps add some detail. We have been working closely with the Scottish Government to ensure that we have good dialogue about our additional costs. We have had substantial additional costs, and we have assurance from the Scottish Government that it will support us with those. The costs will continue throughout the year.

Clearly, we have issues with things such as personal protective equipment and additional staffing. Although some of the costs are being centrally funded, we have additional costs. In

addition, with the elective programme and other programmes, the throughput is not at the level that it was at before, so we are considering how to maximise the number of patients that we see. There is also the continuation of red and green pathways and infection control processes. We are working closely with the Scottish Government, and we expect that there will have to be some additional funding this year.

I will pass over to Mark White to talk about the detail of that.

Mark White (NHS Greater Glasgow and Clyde): Good morning. As the chief executive mentioned, we have been working closely with the Scottish Government. We have put a detailed monitoring process in place to record, submit and monitor the additional costs due to the Covid outbreak, which we are expecting to be significant.

In the return that we submitted to the committee last month, we outlined that, for the first quarter of this financial year, the cost to the health board was just over £60 million and the cost to the six related integration joint boards was about £59 million. We have submitted that to the Scottish Government and expect it to be covered.

As we go forward through the year, there are not many offsets, because 75 per cent of our costs are fixed or staff costs, so we continue to incur them throughout the outbreak and for the rest of the financial year. Therefore, we anticipate that the majority of the Covid costs will be additional, although there are minor elements of savings to be made.

Under the process, the Scottish Government sought a return from every health board covering the first quarter. That was submitted 10 days ago, it is being analysed and funding allocations are due at the end of September. That is a complicated process. There is clearly a lot of additional cost. The Scottish Government is assessing that at the moment and analysing the process for allocating those funds to health boards. As the committee knows, the normal process is to use the NHS Scotland resource allocation committee—NRAC—formula, but it is a complex situation, so that is being reviewed.

I hope that that answers the three elements of the question.

The Convener: Yes, it does. That review of the funding formula or the way in which the funds are allocated will clearly be of significance for boards across the country. The committee will no doubt seek to find out more about that in due course.

I would like to ask Jane Grant whether there been issues with meeting the demand for Covid-19 tests in NHS Greater Glasgow and Clyde. If so, have those issues been overcome?

Jane Grant: There are various elements to testing. There is the capacity for staff and the population to access tests and then there is the processing of the tests.

We have adequate capacity in NHS Greater Glasgow and Clyde to process the tests that are coming in at the moment and we are supporting some of the care home testing. We have moved some of that back into the national health service labs to reduce the wait for that testing through the alternative process—the Lighthouse labs. We are in active dialogue with the Scottish Government and have transferred 1,000 tests to the NHS labs this week to support the wider testing regime.

Access to testing for the population is a wider issue than Greater Glasgow and Clyde, as you will be aware. We are working closely with our IJB and health and social care partners to ensure that they have access to testing. It has not been a huge issue for us but, as you know, there have been some glitches with the waiting time for test results. However, there is adequate capacity in the NHS labs in Greater Glasgow and Clyde at the moment.

The Convener: Do you have any concerns about the availability of testing as go forward? Clearly, there may be an increase in cases and I guess that there will be other pressures on your lab services as well as on your general health service as we enter autumn and winter. Do you have any particular concerns about that forward look?

Jane Grant: We still have some additional capacity in the lab processing part of testing and we have a plan B that would give us additional capacity should there be a further spike. We are also working with the west of Scotland boards to see whether we can get some resilience across the west. At the moment, we have plans that would enable us to increase our capacity by a reasonable amount should there be additional requirement, and we currently have additional capacity, as well.

Emma Harper: Good morning. I have some questions about the long-term implications of Covid-19. The coronavirus pandemic has led to changes in service delivery; health boards have given the committee information about changes in the way in which they have approached that. Can you help me to understand what changes in service delivery are likely to be retained once normal provision resumes?

Jane Grant: As you have heard from colleagues elsewhere, we have moved a lot of services on to the digital Near Me facility. That has been very positive, and we have received good feedback on that from our patients. We are looking to further increase our Near Me capacity. We are using it across the acute sector and the

partnerships to ensure as much as possible that patients do not have to travel. There will be some patients who will need face-to-face appointments, but we are using Near Me telephone consultations and face-to-face appointments where appropriate.

We have set up acute phlebotomy hubs, because quite a lot of the out-patient activity requires phlebotomy and blood tests. We have therefore set up the ability for patients to go safely to a number of acute sites and have their blood taken so that they can have a virtual consultation. That is working well, and we are planning to look at how we might move that approach into the community in the fullness of time. We want to do that quickly. That approach has now been established to be working well, and we will retain it.

We are also looking at alternatives to endoscopy because, as members will be aware, that is an aerosol-generating procedure. That has been difficult for us in some of the endoscopy set-ups. We are looking at alternatives such as capsule endoscopy and the cytosponge, and we are working closely on those alternatives with the Scottish Government. They would provide additional options for patients.

We have established mental health assessment units, which people have gone directly to. There are currently two of them in Greater Glasgow and Clyde, and we are looking at their continuation.

Virtual visiting has been very positive for patients, who cannot have the same number of visitors.

There are quite a lot of different things going on that we hope to retain to assist in the new processes.

Emma Harper: Have all the changes that you have described required additional funding? Will they require additional funding input in the future?

Jane Grant: We can move our current resources for a number of the changes, but some will require additional funding if we want them to be completely separate entities. We are trying to review where we can have substitution for service provision and where we need additional funding. As members will be aware, there is capital investment for things such as virtual visiting and Near Me. We think that, in the fullness of time, we will be able to utilise some of our resources in a different way. There will undoubtedly be some additionality, but we think that we can fund some of the changes with the resources that we have.

Emma Harper: Last week, I asked questions about shifting the balance of care. We know that the goal is to have more care provided in the community rather than in acute care settings. Do the changes that you have described help to support shifting the balance of care from hospitals to community settings?

Jane Grant: We have been working very closely with our health and social care partnerships on issues such as moving the phlebotomy hubs out into the community. We have a very good whole-system working approach, and they have been looking at how to augment their services in the community. There has also been work with the care home liaison service to ensure that the health service, our IJB colleagues and our council colleagues work together to ensure that, where appropriate, patients can remain in their home if that is the best place for them to be.

Emma Harper: Do you expect there to be any impact on the set-aside budget?

Jane Grant: In the current set-up, we do not have that level of detail. Obviously, the emergency flow is not in its normal state. There will have to be a review of the whole emergency patient flow, but I will turn to Mark White to give details on the set-aside budget.

10:15

Mark White: It is a good question. Ultimately, yes—we hope that there will be an impact on the set-aside budget. It is a bit too early to tell, because the impact is probably too difficult to measure with the complexities around the current set of provision of services in the community. However, we hope that there will be an impact in the longer term. We will revisit that set-aside process when things settle down and we are able to work through it to come up with a definitive answer.

George Adam (Paisley) (SNP): Good morning, everyone. I want to ask about how we have dealt with integration during the pandemic. What lessons have we learned about integration during the pandemic? Has the promise of integration been realised during the pandemic? What were the key challenges?

Jane Grant: We have a good working relationship with our six IJBs and partnerships within Greater Glasgow and Clyde. As part of that, we set up a strategic executive group, in which two of the chief officers are key members, and all our six chief officers are part of our corporate management team.

We have augmented our whole-system work in the past six months: the HSCPs have a tactical group that feeds into the strategic executive group, and we have been able to do a lot of work swiftly. Issues that have been raised at the tactical group have gone up to the strategic executive group for support, so we have been able to make decisions

in a whole-system way and more swiftly than before.

With regard to integration, emergency pathways clearly require the whole system to work in tandem. It is therefore important that we have a good understanding of the whole patient flow and patient pathway, which integration has supported in the past six months. We have done a lot of work in that period and before it as well. The committee will have seen examples of how we have all worked differently around care homes.

We have also augmented integration with regular, frequent dialogue between me and the six local authority chief executives, so that we all have an understanding of our key issues across the system. It is a complex system when there are six HSCPs, but it is working well, and the liaison processes that we have put in place have helped us and supported that process.

George Adam: I understand the challenges that you face because you work with so many IJBs, local authorities and partners. One of the things that always amaze me is that we have talked about integration of health and social care for years, but we now seem to hear from you and some of your colleagues on other boards that it has taken a worldwide pandemic to get to the stage at which people talk to one another, break down the barriers and deal with the issue. Why is that the case? Why could we not have got to that place before we ended up in this emergency situation?

Jane Grant: In Greater Glasgow and Clyde, our whole-system work has been good until now and we have a regular dialogue in our partnerships. We already have a good dialogue with the chief officers who are part of our corporate management team, and the six chief officers attend the NHS board meetings. As with everything, when a pandemic comes, you have to do things swiftly because it is an emergency, but that applies in a lot of issues. However, it is right that we need to reflect on whether some of those issues could have been dealt with more swiftly.

We have licence to learn about how we engage with six partnerships in a co-ordinated way to make decision-making processes slicker. The legislation requires us to have whole-system plans across Greater Glasgow and Clyde and we will progress those over the next wee while in a positive and integrated way across all partnerships and health boards and other organisations.

George Adam: You keep talking about how you have augmented your processes and are dealing with things swiftly. You said that you have found ways to cut red tape so that you can communicate with one another, which is your number 1 challenge. Will you give a practical example of something that you do differently now or did not do previously?

Jane Grant: We have been working across the whole system on a flu vaccination plan. Public health colleagues have been working with the partnerships, because we have a significantly greater programme this year than we have had before. We have used some of the corporate resource, some of the public health resource and some of the chief officers and partnerships resource to make sure that we have an integrated flu vaccination plan.

We have established a number of different approaches to care homes, with our director of nursing, our director of public health and colleagues in partnerships. Integrated groups across Glasgow and Clyde are looking at issues that arise every day in care homes and ensuring that we have a co-ordinated approach across the board.

Those are a couple of examples of approaches that are significantly different from what we had before.

George Adam: Has the experience of the pandemic highlighted improvements in the structures that you have in place for decision making and, in particular, resource allocation? I think that it has done. Will those structures remain in place when you are no longer dealing with the pandemic?

Jane Grant: As I explained, we have a strategic executive group, which meets three times a week—it meets twice a week on what I would call ordinary business and once a week on remobilisation. We intend to retain that approach and its positive aspects, so that we can be fleet of foot in making decisions.

On resource allocation, issues come forward for consideration and we make sure that we have an integrated approach, with chief officers, our acute colleagues and our corporate colleagues on groups. Under that level, we have three tactical groups: one for partnerships; one for acute; and one for remobilisation. They will remain, certainly for the foreseeable future, to support the corporate management team in making decisions. There are resource implications, and cases go to the groups for consideration before anything of significance comes to the corporate management team.

Brian Whittle: What assessment has been made of the indirect health impacts of Covid-19 and the lockdown? I think that all members have been contacted by constituents about problems to do with, for example, mental health services, chronic pain services, diabetes clinics, cancer screening and venous thromboembolism—I do not know how to say that—services. The way in which the NHS had to deal with the pandemic during the

lockdown basically pushed such issues further down the list. Has there been an assessment of the pressure on the NHS and how that will come down the line?

Jane Grant: Yes, there has, on a number of issues. We are looking at a national prioritisation process, whereby patients are prioritised on the basis of their clinical need by our clinicians. There are patients who require emergency care and patients who require less urgent care, and the process of clinical prioritisation is under way. Clearly, it will take some time to clear backlogs.

We have been considering mental health and we are running additional sessions to make sure that some of the backlog is addressed.

We have a comprehensive remobilisation plan, which describes how we will try to increase the number of patients that we see, in the shorter term, to reduce the backlog.

Brian Whittle: A couple of issues—such as those around chronic pain clinics and the impact of chronic pain on quality and even length of life—have been highlighted consistently. We also know that the number of cancer screenings went down significantly, which has to mean that an impact is coming down the line. Did the lockdown strike the right balance between minimising the potential indirect health impacts of those issues and the obvious direct health impacts of Covid?

Jane Grant: It is difficult to strike the right balance. We acted, in co-ordination with other boards, on the information that was available to us throughout the pandemic. We were all learning, and that balance is difficult to strike.

We recognised things such as chronic pain as a priority and we have put effort into making sure that we have a recovery plan to get those patients seen quickly. Throughout the organisation, there are a lot of patients who require more urgent care. We have to prioritise them, and we are trying to do that at the moment.

Cancer screening is a difficult issue. We have had to utilise our resources in a different way because of the number of urgent patients that we have. We will augment our cancer screening processes, but I am afraid that there is not an easy answer to Brian Whittle's question. We have to balance the resource that we have with our ability to manage all those areas.

Brian Whittle: I totally recognise the issues that you face. One of the things that we need to consider is how we manage patients' expectations. Aligned to chronic pain is elective surgery such as hip and knee replacements. We know the positive impact that such elective surgery can have on people's lives; we also know the negative impact that it can have if they do not get it, and the further pressure that that puts on the NHS.

I will ask a couple of final questions. What impact is Covid-19 continuing to have on your service capacity? Is there an estimated timescale for recovery to pre-Covid performance levels? Will we ever get back to pre-Covid performance levels, especially in areas such as elective surgery?

Jane Grant: In our remobilisation plan, we made commitments to return to 80 per cent of last year's out-patient activity by the end of the year and approximately 60 per cent of our in-patient day-case capacity by the autumn.

As the committee will be aware, a number of processes have to be put in place to make sure that patient pathways are safe. We have to maximise productivity, but we also have to make sure that all the processes are safe for patients, which will reduce the number of patients that we can see in a session.

As I explained, we are trying to maximise the use of Near Me and virtual technologies for out-patients, on which we have had positive feedback. We are putting a lot of effort into that to make sure that patients who are able to access that kind of arrangement do so, which will help us to get through some of the backlogs. However, that does not suit every patient and we need to be person centred.

In-patient day-case activity, along with endoscopy, is more complicated. Nonetheless, we are doing additional sessions to try and reduce those backlogs on a clinically prioritised basis.

Whether we will ever get back to our pre-Covid level of throughput remains to be seen. It depends on some of the issues around infection control and so on. It will certainly take us some time to get back to the level of performance that we had prior to Covid.

David Torrance (Kirkcaldy) (SNP): Good morning, panel. How has the demand on hospices been affected by the pandemic?

Jane Grant: We have been working closely with hospices to try and support them. They have also been given some resource in order to support them. We work closely with them and we have used their services, but it is an area in which we have further work to do. Hospices are certainly high on our agenda. They work well with us and the partnerships closely liaise with them.

David Torrance: Is it anticipated that, following the reduction in planned care and diagnostic testing during the pandemic, future demand for hospice care will increase? If so, how will that be funded?

Jane Grant: I am afraid that I did not hear the question. Could you repeat it? Are you asking what the demand for hospices will be?

10:30

David Torrance: Yes. Will there be an increased demand for them and, if so, how will that be funded?

Jane Grant: I am not sure that we have looked at that in detail. It is a good point with regard to how we go forward with the planning for hospices. We have been working closely with them, but in terms of planned care and so on, I do not think that the impact has really been assessed carefully, and it might be that in due course we have to augment hospice funding. Mark White can give you some detail on how we fund hospices.

Mark White: On funding, £4.2 million has already been received from the Scottish Government and passed to hospices. That happened almost at the start of the escalation of the pandemic, in April and May. We have allocated some funding, and I have no doubt that there will be more.

The model for funding hospices is very complex. There are differences across hospices, with some funding coming from us, some from the Scottish Government and some from the hospices themselves. As the chief executive said, we will have to review that area much more closely and assess it in terms of the whole new world—I was going to say the post-Covid world—that we are about to enter in the next six to 12 months with regard to all our funding, considering that we always have to be ready for further spikes.

David Torrance: This is my final question. What other services that are commissioned by the IJBs have received increased funding as a result of the pandemic? Is it anticipated that that extra funding will need to be continued?

Jane Grant: There has been additional funding for health and social care partnerships. I will pass the question to Mark White, who has the detailed knowledge.

Mark White: It goes back to my point that the tranche of funding that the IJBs have so far received directly is the element for hospices, which I just mentioned. Just over £2 million has also been allocated to fund the living wage. The integration authorities have received another tranche of £11 million, which was pretty much a part payment for some of the external services that they purchase to keep some of the organisations sustainable. Another allocation has gone straight to general practitioners; that also came at the start of the pandemic. All in all, just over £20 million has been allocated through NHS Glasgow and Clyde to our six IJBs so far.

As I mentioned in my opening remarks, we have also submitted a first quarter return. That includes around £140 million of spend for the whole year for our six IJBs. As I said, that is being analysed by the Scottish Government, and we hope that it will form part of the settlement that we are expecting at the end of September.

Sandra White (Glasgow Kelvin) (SNP): Good morning. I want to push a little bit more on the retention of innovations. In your answer to Emma Harper, you spoke about retaining virtual visiting in accident and emergency and innovations in mental health care. You say that you hope to retain those innovations, but are there any others that you have adopted during lockdown, particularly in digital, that will be extended? Do you have any other ideas in that respect?

Jane Grant: There is Near Me. I will not rehearse what I have already updated the committee on, but there would be huge potential in maximising Near Me across all our specialties, including mental health and some of our allied health professional services. There is still quite a lot of potential to maximise that, which we are in the process of doing but have not completed. That work will continue.

We would certainly want to augment some of the remote monitoring processes. We have done a little of that, but we have much to do in that arena as well. In general, those processes have been positively received by patients.

We have used things such as consultant connect, which is a process whereby GPs can talk directly to consultants within the hospital. That has proven to be a positive direct access route for GPs and primary care colleagues; it will continue and be augmented.

We have used Microsoft Teams for all our meetings and so on, which was a little challenging at the beginning, but we are now well into the way of it and using it routinely.

There are many areas where we use digital. We are going down a route on digital, but there is much more to be done, and we are absolutely committed to doing it. We see it as one of the cornerstones of our future service provision.

Sandra White: You mentioned digital being a bit difficult—we have come across that, too, particularly with connections.

You said that you are going to scale up on digital. Have there been any barriers, such as infrastructure issues, that have prevented you from making progress with the digital aspects of innovations, whether those that you have just mentioned or others?

Jane Grant: Our e-health team in the health board is very proactive and forward looking and has certainly overcome a number of barriers. Undoubtedly, we will need to provide more resource for that team if we want to move increasingly into the digital world. However, to date, the team has overcome the technical challenges.

We have to be cognisant of the fact that, for a cohort of patients, digital channels will not be best. We are therefore ensuring that we do not assume that that approach suits everyone, because it will not. We have been working with our local authority colleagues and our chief officers on digital exclusion to look at that aspect of the digital agenda. Until now, our e-health colleagues have done an outstanding job in supporting the board and its work.

Sandra White: To follow on from that, a recent board paper that you produced mentioned that a review and evaluation of service models will

"ensure that the patient experience is maximised."

What will that evaluation involve? Will you ask patients how they felt about the digital innovations and how good the experience was for them?

Jane Grant: Absolutely. It is important that we do not assume that one size fits all; it is also important that, if there are challenges for the digital agenda, we address those as we go forward. That is why we get patient feedback, through surveys and so on. We ask people to give us their views. So far, the feedback has been positive but, as I say, the digital approach will not suit everybody. We need to ensure that patient and service user views are incorporated in our vision.

Sandra White: That will be reported in the board minutes, but will the committee be able to see the evaluation feedback?

Jane Grant: Yes, absolutely—in due course.

Sandra White: Convener, I have a couple of other questions, but should I wait until other members have come in?

The Convener: No—go on if you have remaining questions.

Sandra White: I have to scroll down, so I am sorry about the pause. It is to do with the way that the question paper has been produced. I apologise to the witnesses.

Some of my questions have been answered, but I have a point about the resource implications of Covid-19. The first question is straight to the point. What is the latest estimate of the additional costs resulting from Covid-19 for NHS Greater Glasgow and Clyde and the health and social care partnerships? Mark White gave a slight indication of that in response to the convener, but perhaps he could follow up on that.

Mark White: [*Inaudible*].—which is what costs we have incurred to date and what costs we are projecting for the remainder of the year. The submission that we gave to the committee, which is probably the most accurate assessment that we have at the moment, took account of the first quarter, which was April, May and June, which was at the peak of the pandemic. For the health board, there was an additional cost of £61 million for that period and, for our colleagues in the six IJBs, there was an additional cost of £60 million. That is for the first quarter.

In total, covering the whole financial year from 1 April straight through to 31 March next year, the projection for the health board is that there will be £190 million of additional costs—that includes remobilisation as well as Covid. The total cost for our IJBs is projected to be £144 million, which again is for Covid and remobilisation.

Because of the financial situation in NHS Greater Glasgow and Clyde, a large part of the costs is unachieved savings—the figure is about £70 million. That is the opportunity cost, if you like, of spending our time delivering Covid services and of our focus on remobilisation rather than on saving money, which is normally front and centre in our day-to-day business. However, we are getting back to that so we expect that number to come down.

That is the totality and, as I mentioned, we are currently in negotiation with the Scottish Government about supporting that.

Sandra White: Those are huge amounts of money. Have there been any reductions in expenditure—on medical supplies, for example? Have you been able to save any moneys?

Mark White: Yes, there have been minor offsets. Our elective programme was greatly reduced during April and May, but it is picking up again. Unfortunately, any offsets and reduced areas of spend that we find are well overtaken and superseded by additional areas of cost.

There are areas where we are spending less money, but the challenge is twofold: whether we can realise that saving and the fact that some of it is temporary. For example, on our repairs and maintenance bill for the whole 12 months, clearly, we had hardly anyone on site—external contractors and so on—to fix things during April and May, but we will have to accelerate that in the remaining seven or eight months of the year to catch up. The finances tell us that we did not spend money in certain areas during April and May, but we cannot realise that saving because we have to catch back up.

Sandra White: Basically, although you may have saved in other areas, you have not really saved at all because there will be extra expenditure in the coming months.

Mark White: Absolutely. [*Inaudible*.] Within those numbers we have made a range of assumptions. At the moment, we are assuming that we may have to increase our intensive care capability again to the levels that we had back in April and May. We hope that that will not happen, so some of those assumptions may not materialise. However, those are our projections, given the information that we have at the moment.

Sandra White: That was my last question. Thank you very much.

The Convener: Thank you. I call Donald Cameron. Can we make sure that Mr Cameron's microphone is on? That sounds promising. No—we will go to David Stewart now and come back to Mr Cameron.

David Stewart (Highlands and Islands) (Lab): I have a few questions about delayed discharge. Would the witnesses agree with the report on lessons learned that during the pandemic

"medical staff were leaving social decisions to social care teams"

and that that led to a reduction in delayed discharge?

Jane Grant: We have reviewed our processes for delayed discharge to make sure that the dialogue between our clinical staff and social care staff—social workers—has been augmented. A revised process is in place and good communication between social workers and ward staff—nursing and medical—is required.

The dynamic has improved during that process. We are keen to continue with that—to augment it further and to ensure that there is one process across NHS Greater Glasgow and Clyde. The six partnerships are working on that now, with a view to having one process where there were different processes, before. That is one of the changes that we have made.

David Stewart: Will you talk the committee through the number of beds that were occupied per day due to delayed discharge over the period from March to July? You will know that in your board there was a less marked reduction than there was in other health boards. Why was that?

Jane Grant: We saw a reduction in our delayed discharges at the beginning of the pandemic. The number reduced by a reasonable amount, but since then the number has risen a little. At the beginning, in March, we had about 170 people. The number reduced to substantially less than that, but is climbing again.

10:45

There are issues to do with adult patients with incapacity and our ability to work with families, because we are very keen to support them. We have also to make sure that we have the correct processes in place for testing; there has been some complexity around that.

We are working hard to ensure that the patients are in the right place for them at the right time and that, when they do not require to be in an acute bed, they are moved in an appropriate and balanced way.

David Stewart: How can reduced levels of delayed discharge be sustained, moving forward? Is ingrained behaviour as important as finance?

Jane Grant: The issues within Greater Glasgow and Clyde have not been principally about finance, but about process, adults with incapacity—which has been a difficulty for us—and family dialogues. We need to make sure that we have constructive conversations with families at the right time, because we want to be person-centred and to make sure that families can influence what is happening. There has been dialogue around that, but it has to be done in a focused way in order to ensure that patients do not sit too long in the acute sector when that does not suit their needs. We have work to do on that; it has been an issue for Greater Glasgow and Clyde for some time. We are working closely with our partnerships to make sure that such dialogue takes place within each ward environment.

David Stewart: Thank you. I have a final question. Have you assessed the cost benefits of reducing delayed discharge in the long term?

Jane Grant: I will answer first, then Mark White can augment my answer.

Our primary focus has been to ask where the best location is for patients to be treated. We would start with the idea that, where appropriate, care at home is the best thing for patients, and only when that is not possible would we consider care homes. That is a discussion to be had with our health and social care partnerships, because if patients in the population can be supported in their own homes, that is usually the best place for them. However, there are occasions when that is not possible and patients go into care homes. That level of care is less expensive than the acute sector, but finance has not been our primary overarching consideration. The process has been about asking, in conjunction with patients' families, where the best place is for them to be treated. Mark White will talk about the detail.

Mark White: As Jane Grant said, it is a complex process. We always assess the process of delayed discharge as being about much more than

the money. It is about what works best for our patients, and acute settings are not always the answer. The general thinking around the health economy is that the cost in a community setting can be as low as a quarter of the cost of keeping a patient in an acute setting, and the cost of treatment at home can be even less. In the Covid and post-Covid world, the costs will probably change slightly, but not greatly. The process of moving people into the community setting and reducing our delayed discharges will always be cost beneficial, but as I mentioned, a huge range of other non-financial factors must be included in the calculation.

The Convener: I now call George Adam.

George Adam: Thank you, convener; you took us all by surprise there.

I will ask a question about primary care in NHS Greater Glasgow and Clyde. Last year, the committee took an interest in that area, when we undertook a major inquiry into primary care. Obviously, things will have changed during the pandemic. How much additional funding was paid to general practitioners to compensate for remaining open during public holidays and the additional costs of the current pandemic situation, such as for deep cleaning and PPE?

Mark White: As I think I mentioned at the start of the meeting, £4 million was allocated to GPs through NHS Greater Glasgow and Clyde. The specifics of how that was spent and what it was to cover might not be transparent or clear. GPs are independent contractors, so the funding that is given out is offset against whatever each GP sees as being relevant.

The majority of the PPE that was given to GPs—and to all independent contractors—came from the Scottish Government. The independent contractors were not charged for it. At the beginning of the pandemic, some of those independent contractors purchased their own PPE, to get them over the initial hurdles. However, following that, PPE came through from the Scottish Government.

So far—to recap—£4 million has come to our GPs through NHS Greater Glasgow and Clyde. Inevitably, as I have mentioned, more will come in the funding settlement at the end of September.

George Adam: Thank you for that answer.

One of the concerns that came up for the committee during our inquiry last year was the specific role of GPs as contractors. Most of the public do not know that they are contractors; they assume that they are part of the NHS. Speaking for myself, rather than for the whole committee, I say that I still find it concerning that we cannot really trace what was actually done with the £4 million that was sent to GPs. In effect, there is no audit trail for us. That is always a concern for the committee. Is it a concern for the board, as well?

Jane Grant: Processes are in place to track expenditure of what has gone to general practices. There are also various fora in which our primary care colleagues work with GPs to ensure that appropriate checks and balances are in place. There is a mechanism whereby our primary care team looks at the finance that is allocated to GPs. It is not quite as invisible as you might imagine.

However, the independent contractor set-up is certainly complex. We have a team that works closely with our GP colleagues, in a constructive way, to ensure that service provision across Greater Glasgow and Clyde is adequate, and that where there are genuine resource requirements, we support our primary care colleagues, who are really important in the whole system of service provision.

George Adam: Just to consider that in a more practical sense, is a process in place for measuring the workload of GPs during the pandemic? If so, how does the workload compare to pre-Covid levels?

Jane Grant: The ability to measure workloads in general practices is part of the new general medical services contract. However, our partnerships and chief officers work closely with their local GP colleagues.

We also have a deputy medical director, who is a practising GP. We work closely with that person to see what additional work there is, and we agree with them what service provision needs to look like. Therefore, the resource should follow. We are certainly working with them, but matters such as the numbers of patients GPs have seen are part of the new GMS contract. The contracting set-up for GPs is different from that in the acute sector, which is altogether a different environment.

George Adam: Okay. So, are you aware of whether GPs are busier or not busier than they were pre-Covid? Are you aware of what GPs are doing, as highly paid contractors with the board?

Jane Grant: We set up the community assessment centres and the GP hubs. GPs have been supporting those processes, which means that they have had to augment or change their normal ways of practice working in order that they can help us in the community hubs and GP hubs. They have done significant additional work on top of their normal day job, and in a different way. GPs have supported the whole system across Greater Glasgow and Clyde very well. Had we not had the community assessment centres, GP hubs and so on, we would not have been able to separate the Covid and non-Covid pathways.

GPs have done a huge amount in addition to their normal activity. Their base activity—if I can call it that—is perhaps a little reduced, because more patients have gone through the community assessment centres and GP hubs, but as the acute sector has done, they have augmented their service provision in other ways: they have embraced telephone and virtual consultations, for example. They have had to amend their service provision in the light of Covid, just as the acute sector has done.

George Adam: When the committee was doing an inquiry into primary care, we all got excited about the various ways of delivering services and the new ideas in that regard. No doubt you are excited, too. Has Covid-19 resulted in more care being undertaken by primary care professionals other than GPs? During our inquiry, we heard that there might be better ways of doing things.

Jane Grant: There are a variety of areas in practices, through the primary care improvement plans, where the multidisciplinary team is augmented. That was going on before the pandemic and has continued throughout it. In the GP out-of-hours service, we are augmenting the role of advanced nurse practitioners, and we are looking at how allied health professionals and so on can support the work of GPs differently. We went out to recruitment recently for individuals to support the GP out-of-hours service, and we are looking at how pharmacy colleagues in general practices can help with drug queries, mental health assessments and so on. A lot of work is going on the arena of GP in-hours and out-of-hours services.

Emma Harper: Are you measuring how use of community hubs and GP hubs has reduced visits to emergency rooms during the pandemic?

Jane Grant: We saw a reduction in attendance at accident and emergency departments, but A and E attendances in Greater Glasgow and Clyde are now back to 80 per cent of what they were. We also have patients going through the community assessment centres, some of whom are referred on to the specialist assessment and treatment area—SATA—which is, in essence, a Covid line in the acute sector. That process is in addition to the emergency department process.

Processes have been redesigned completely. The counting mechanism shows fewer emergency department attendances, but we have the SATA pathway and the Covid hub processes, which were not in place before.

Donald Cameron (Highlands and Islands) (Con): I want to ask about the prospect of a second wave of the virus, which is very difficult to predict. What planning has been put in place to ensure that the board is able to deal with a surge in Covid-19 cases over, say, the next six months?

Jane Grant: As part of our remobilisation plan, we have been looking at what is urgent, and have been ensuring that we make as much progress as possible with our urgent cases, in case there is a second spike.

In April, we had in excess of 600 in-patients at any one time, which was a significant proportion of the patients in the acute sector at the time. We also had to double and triple our intensive treatment unit capacity. That is the big challenge for us. ITU capacity is normally 45 beds, but we got up to almost 80 patients. At times we thought that we might have more, so we planned for that.

Just now we are considering options for ensuring that our urgent patients do not have to wait for a long time, so that we will be in a good position if we go into a second spike. We are also looking at how we can augment the normal winter plan—if I can call it that—in the context of the need to put a lot of effort into flu vaccination, to reduce the routine winter additional emergency flow.

Plans are under way to make sure that we can support urgent and emergency patients in a positive way, and that delays are minimised. We are also planning to ensure that, should there be a second spike, we would go into it with pathways much better defined than they were the last time. We need to use anaesthesia colleagues to support the intensive therapy unit, which is the big challenge for continuing with elective work. Our theatre staff have all been trained to support ITU, should they need to do that again, but that would obviously impact on elective work, so we need to make sure that urgent patients have been addressed in the clinical prioritisation that I talked about earlier.

11:00

Donald Cameron: Thank you. You covered my next question in your answers, but just to be sure, can you confirm that you are taking steps to ensure that some clinical activity can continue, should there be a second spike?

Jane Grant: Absolutely—we are doing that. We need to make sure that our emergency and urgent patients have access to healthcare when they need it, and they are absolutely centre stage in our planning.

Donald Cameron: The convener asked you several questions about testing. I want to pursue that a little bit further, given its importance should a second spike occur. Can you confirm approximately how many tests per day your board is carrying out? What is the actual capacity?

Jane Grant: Our labs are processing between 9,000 and 10,000 test a day. We are now also moving 1,000 patients from care homes into NHS lab processing. We are just finalising whether we can do another 4,000 to 5,000 patients. We have some spare capacity and we will be moving additional care home work into the NHS, but we need to keep some spare capacity, should there be additional requirements going into the winter.

Donald Cameron: Thank you. I now turn to a different issue—the NHS workforce. What impact has the recent increase in cases of Covid-19 had on staffing levels? For example, have you seen an increase in absences?

Jane Grant: At the peak of the pandemic, almost 2,000 staff were off, and in excess of 1,000 of those were shielding. Most of them have now returned. At the moment, we just have just over 300 people off, so we are in a much better position than we were when we had staff shielding; we are in a reasonably positive position, at the moment. We have been augmenting our staff with additional staff to ensure that staff are available should there be a second peak or winter pressures. We are augmenting staff levels, but we are in a better position now than we were.

Our overall sickness levels improved slightly during the Covid pandemic, but we also had what I would call routine sickness absence as opposed to Covid sickness absence. Those routine sickness levels have been relatively stable, compared with the Covid additionality absence levels.

Donald Cameron: Is it easy to measure the impact that has had on the delivery of services in the past six months?

Jane Grant: That is quite hard to measure, because a number of people were shielding and we also had to redeploy a lot of staff into different roles. When we are redeploying with that level of absences, it is quite difficult to measure in that binary way. A significant number of factors impacted on our ability to deliver services, among which shielding was a substantial factor. We had some people who could work at home, but some of our clinical staff were clearly unable to do that, which certainly had an impact. We are augmenting our virtual processes to maximise people's potential for working at home or outwith clinical facilities, although there is clearly a limit to the appropriateness of that.

Donald Cameron: In some of your answers, you have touched on workforce planning and have talked about the augmentation of staff. Can you describe the more general workforce planning that has taken place to ensure that the board has a flexible workforce that can respond to the increase in cases that we might see over the next six months?

Jane Grant: We are considering our base level of staffing to ensure that the areas in which we anticipate increased challenges have been appropriately resourced, as well as increasing our test and protect workforce so that we can respond to the tracing requirements. We are also looking to augment our staff banks, should there be a need for flexibility, and we have taken on a significant number of students who have just graduated from universities to ensure that adequate staffing is in place as we go into the winter.

The Convener: I thank Jane Grant and Mark White from NHS Greater Glasgow and Clyde for their participation and their full answers to our questions. We might have one or two remaining questions, which we will send in writing after the meeting.

We now move to our second panel on pre-budget scrutiny, which represents NHS Lothian. I welcome Calum Campbell, who is the interim chief executive of NHS Lothian, and Susan Goldsmith, who is its director of finance. We will take questions in a more or less pre-arranged order and will endeavour to ask the full range of questions in the time that we have.

As I did with the previous panel, I ask for a general picture from Calum Campbell and Susan Goldsmith. On balance, how far do you expect the additional costs from Covid-19 to be offset by reductions in expenditure elsewhere? What additional costs do you anticipate over the full financial year? To what extent do you expect the Scottish Government to provide funding to meet any additional costs that have been incurred?

Calum Campbell (NHS Lothian): I will give a brief introduction, and Susan Goldsmith will provide some detail. Similarly to NHS Greater Glasgow and Clyde, we are seeing additional costs come through with little that we can offset. In the early stage of the pandemic, we had to stand up our ITUs and bring in additional staff, with significant costs around PPE. Activity is now returning to normal, but we still have to deal with a pandemic. Susan can provide some of the figures behind that picture.

Susan Goldsmith (NHS Lothian): We have worked closely with colleagues across the finance community to assess the costs of Covid. In NHS Lothian's July results, we reported an overspend of £27 million—38 per cent of which related to what we accounted for as Covid costs, with an offset of just under £15 million. We are still working on the assessment of our year-end position for the board, but our initial submission to Scottish Government colleagues was that the entire cost would be £119 million by the end of the year, which does not include social care. We are revisiting that figure at the moment, and we are working with Scottish Government colleagues on

the back of that assessment to agree how the Scottish Government will distribute its additional available resources across the health boards.

The Convener: We heard from Mark White that a review is on-going of how that money should be distributed—[*Inaudible*.]—referred to by Susan Goldsmith. Are you able to tell us any more about that? Those costs are real spend rather than estimated or formula-based figures, although most revenue funding is allocated on the latter basis. What is the difference in approach between the two? How quickly do you anticipate an agreement on the basis for that allocation, and what are the implications thereof for NHS Lothian?

Susan Goldsmith: As you know, most resources come through the NRAC formula, but, early on in the pandemic, it was recognised across the finance community that that might not necessarily be appropriate, because the boards have seen different changes in their cost profiles. We have been working to assess where costs are driven by population size—for example, some of our capacity on public health and test and protect is very population driven—and where costs are driven by the way in which Covid hit boards. There was a greater impact in Lothian and Glasgow initially, and there was less impact the further north you went.

We do not yet know how the resource will be distributed, but I know that a lot of work has been done to ensure that the allocations recognise not only the demographics of boards but how costs have been incurred across the system. However, we are all working on the basis that the costs that we have incurred will be met by funding from the Scottish Government. Naturally, we are trying to ensure that the costs relating to our original financial plan, before Covid, are delivered with a break-even position but, as Mark White said, some areas that are in our normal financial plans, such as the delivery of savings, have been compromised by Covid, so we have included those in our overall assessment of the costs for the board.

The Convener: I have two further supplementary questions. Can you confirm that you are saying that it is agreed across the piece, including by the Government, that NRAC is not the appropriate basis for meeting the costs that have been incurred during the pandemic?

Susan Goldsmith: It is not so much that NRAC is not appropriate; it is just that the money will not be distributed solely on the basis of NRAC. We are trying to get a mixed model that recognises that some costs are driven by population, in which case NRAC is appropriate, but that others are not. There will be a mixed model of distribution of resource.

The Convener: My final question in this territory relates to the projections. If I have noted the numbers correctly, Glasgow and Lothian are both projecting Covid costs in the region of £190 million, which might be quite surprising given the difference in population size. Have I understood that correctly, and is it surprising from your point of view?

Susan Goldsmith: I suppose that, three or four months ago, before the current situation started, I would not have anticipated the costs being so significant. However, as Calum Campbell said, and as Jane Grant and Mark White said earlier, we had to create additional capacity and we had to bring in additional staff to ensure that staff absences were covered. We have had to enhance our cleaning and portering services, and we brought in additional student nurses. Given all the things that we have put in place, the additional costs are perhaps less surprising.

Both boards have included the costs of remobilisation. The figure of £119 million for Lothian is not just for the costs of Covid; it recognises that, for some time, we have not been able to carry out our scheduled programme of work for in-patient day cases and out-patients, as well as some diagnostics work. The estimated costs for the year include provision for trying to recover some of that activity, although we might not be able to source the capacity. Certainly, in Lothian, we will struggle to source that capacity, so we will have to look to the independent sector, which might or might not be available to us. Some of the costs in the remobilisation plan are based on assumptions and estimates of what we think we would need to do to get services back up and running.

Emma Harper: I am interested in the longer-term implications of Covid-19. Witnesses in previous evidence sessions have talked about how the coronavirus pandemic has led to changes in service delivery. Will you implement those changes in a more long-term way? If that is the case, will the long-term changes result in additional costs, requiring more funding for future years?

11:15

Calum Campbell: It is a good question, and I am not trying to duck it, but the answer is both. The benefit that we have had from things such as Near Me and our “call MIA” service—which is a virtual way of giving people a minor injury assessment—is the capacity to reduce cost and demand over time. However, if we have to continue with some of the guidance around infection control—for example, the four-nations guidance—it will put a significant pressure on space. If there is a 2m spacing requirement, that

will reduce the number of beds, which will have to be replaced elsewhere. That will spread staff more thinly and create more wards, which will bring additional cost.

The challenge is in trying to keep all the things that we believe will bring us benefit and more efficiency while mitigating the impacts or risks as best we can.

Susan Goldsmith: It is very difficult to answer that question, because we are still working on it. Calum Campbell is right that there will be additional cost in some areas and some areas in which there might be financial benefits.

Whatever we do, given that we will be changing the way in which some services are delivered, we need, first, to invest in and build up the infrastructure in new services before we will see the release of resources in services that we are currently delivering.

The answer to the question is therefore that there will initially be additional cost as we build up that new infrastructure. Over time, however, we might see some benefit from a reduction in services, which are now provided in a different way. The important issue is the bridging between where those services are now and the future model.

Emma Harper: One of the goals is to shift the balance of care so that it is delivered in more community, rather than acute, settings. With coronavirus, we have seen the use of Near Me, digital technology and community and GP hubs. As we have heard, that means that we are able to start moving things—such as phlebotomy clinics—away from acute hospitals and out to other areas. Would it incur more cost to the budget if the balance shifted in that way from acute care to community-supported care?

Calum Campbell: I am not trying to be clever, but it depends on how you calculate the cost. Certainly, for the individual patient, the closer to home that you can provide care, the less cost—whether in travel or time—there is for them. However, the focus should be on providing the most appropriate care in the most appropriate place, whether or not that is in the acute sector.

The concern that I have about the debate on shifting the balance of care—although I am not sure whether that is where Emma Harper is coming from—is that people perceive that there is an ability to significantly reduce the secondary care sector and to shift resource to the primary or community care sector. I do not share that view, as I have not seen evidence that suggests that we could operate with significantly fewer beds. Nevertheless, I would fully sign up to the fact that we should provide as much care as possible as close to home as possible, provided that it is clinically safe to do so, and that we should not proportionally advantage or disadvantage either side.

Emma Harper: Thanks for clarifying that. Often, when we talk about funding for the integration joint boards, set-aside budget comes up as well. Have you been able to assess whether the set-aside budget will be impacted at all?

Calum Campbell: [*Inaudible.*] I am relatively new in NHS Lothian, so my answer will reflect more on my Lanarkshire experience than on my more recent experience.

We have been dealing with this as a crisis. Although finance is important, my experience in Lanarkshire and Lothian is that chief officers have got together with myself and other senior directors to ask what the right thing to do is. I am not saying that money is not important, but it has been a secondary concern in these times, and we have been focused on getting the best possible response.

I do not know about the impact on the set-aside budget. Perhaps Susan could elaborate.

Susan Goldsmith: Certainly, the set-aside budget will be impacted. Over the Covid period, there was a reduction in the number of emergency admissions. If we were operating the set-aside budget on the basis of activity—that is, if we were charging the IJBs for the activity involved in unscheduled care—there would be a reduction in costs, although the infrastructure costs to the board would be the same. However, as Calum Campbell said, we have not really operated in that way. We have operated as a single system, trying to make our best assessment of the right thing to do in the current environment and to agree the cost profile of whatever we have to put in place without being too concerned with the impact on the set-aside budget.

We are now trying to remobilise services and think about different ways of delivering them. For example, the work on the scheduling of urgent care and on unscheduled care will have an impact on the regulation of the set-aside budget, but that will be about rebasing our budgets across the system. We will start to look at that in more detail as we move through the autumn and start to plan for next year and beyond.

Emma Harper: What we are seeing, and what you are describing, is that the response to the pandemic has involved being adaptable, making changes rapidly and just getting on with the job without focusing on the finances. Do you think that that should be a model going forward? Basically, should we be less concerned about the minutiae of every penny? We heard that the money for pulmonary rehab for out-patients with chronic obstructive pulmonary disease came from the

prescribing budgets rather than from other budgets. Would it be easier for us to just let you get on with it?

Calum Campbell: I will answer, and my director of finance might correct me.

In an ideal world, I would like your suggestion to be the case. However, the reality is that we cannot duck the fact that the health service is a large part of the Scottish health budget and we should be expected to manage it as efficiently as we can and be as detailed as we possibly can be, to ensure that there is as little waste as possible in the system and that we maximise the return from the money that we get. We should not put in place unnecessary bureaucracy, but we have to ensure that we account for what we do in order that we can be sure that we are delivering the best that we can within the resources that are available to us.

Emma Harper: I will leave it there, unless Susan Goldsmith wants to come in.

Susan Goldsmith: I can only confirm what Calum Campbell said. As a director of finance, I would say that looking after the money is very important to us. However, we also need to be flexible, and we are trying to do that while ensuring that, as we deliver different models, we are making the best possible use of taxpayers' resources. I am afraid that the money is always important.

George Adam: Good morning to Calum Campbell and Susan Goldsmith.

I would like to follow up a topic from the previous session. As you might have heard, I asked how the integration of health and social care had worked during the pandemic. The committee has heard from some of your colleagues from other places that Covid-19 has actually helped with integration, and has broken down barriers, and that communication has opened. Has that been the case with you?

Calum Campbell: Any crisis brings people together, if they have positive intentions. I have certainly been impressed by the way in which the chief officers from Lanarkshire and Lothian have engaged with me to talk about how they can do the right thing for the right reasons. That is a benefit that has come out of the crisis.

Integration is a journey and it did not start with the pandemic. In both Lanarkshire and Lothian, we had started long before that. That has brought us some advantages.

To reflect a conversation from earlier this week, we are trying to be as respectful as we can that each of the IJBs can be different, but we are also now having a very sensible conversation about ways in which we can standardise, and reduce variation. That is a good thing to do, and it is a lot easier to explain across the system.

We are on an integration journey. I do not think that this will be the end of it, but hopefully we will take lessons from it.

George Adam: Thank you for that.

You said that you are working on an IJB-to-IJB level. However, as well as working with IJBs, you are working with local authorities, to cover health and social care. Have you been able to work effectively to ensure prompt action and effective decision making? What I mean is, would the man or woman in the street be able to say that the issue that they went in with was dealt with? I was not referring to all the various structures that you have. I know that the structures need to be there; I just want to know whether that helps with the delivery of service.

Calum Campbell: In all honesty, I would like to say "yes", but you would have to ask the public that question.

Examples to evidence my answer include the rapid pace with which we created, set up and developed the Covid pathways, which required the health board, the local authorities and the IJBs to work together. The collaboration on care homes has been good and innovative, but it has been a major challenge that we have had to address. The planning that we are putting in for the return of the universities, for the flu campaign, and for—it is to be hoped—a Covid vaccine are examples of how the local authority, the health board, the IJBs and, sometimes, other partners have worked together.

George Adam: Thanks for that.

Has the experience of the pandemic highlighted any areas for improvement in the structures in place for decision-making processes? Can you give me an example of something that has made a big difference that you have changed dramatically and will continue to work in that way?

Calum Campbell: I would like to answer positively. However, the relationships that I have had have always enabled me to have direct access to chief officers and council chief executives. If there have been issues, we have always been able to move them. The pandemic has brought that into stark focus. At the end of the pandemic, our question must be: was that the best structure to have in order to respond to such a crisis? We will have to ask that as part of the lessons learned review.

George Adam: Thank you, convener. That is all.

Brian Whittle: Good morning to the witnesses.

I am interested in the indirect health impacts of the pandemic.

We know that, before the pandemic, there was pressure on services around mental health, chronic pain, diabetes, cancer screening, COPD and heart conditions, and that pressure has only been massively exacerbated by the current crisis. What assessments have been made of the potential indirect health impacts of Covid-19? Inevitably, more pressure is coming down the track—it is not going to go away. How are you managing that assessment at the moment?

11:30

Calum Campbell: Lothian did not have enough capacity to meet demand prior to the pandemic, which is why we had our waiting times challenges. The pandemic has brought that into sharp focus. We are constantly monitoring the build-up of the backlog that we are going to have, and that will be a significant challenge for us.

I can reassure you that we are using a national prioritisation process that is based on clinical need, but there will be a significant backlog that will take us a significant length of time to address and clear. However, we have to do the right thing and act according to clinical priority. To go back to the point that Emma Harper made, if we can do things outwith hospitals, we should do so. However, we have a concern about our capacity to meet demand.

Susan Goldsmith: I would just add that, given the demographics of Lothian, which has a growing population, there will be a continuing requirement for investment in infrastructure. Before the pandemic, every part of our system was full. Through our capital investment programme, we have business cases coming forward for primary care in recognition of the house building that is under way in Edinburgh and the Lothians. The business case for the cancer centre also recognises the demographic issues, and we recognise that we need capacity in the elective and diagnostic centre. The issue that you raise will continue to be a challenge for Lothian. Now that we have a significant backlog, we will have to access the independent sector to help with that, too.

Brian Whittle: Do you think that public expectations are being properly managed? Obviously, there will be a serious impact on, for example, elective surgery. We have heard that that could rise to 50 per cent or so of the surgery workload.

Calum Campbell: That is a good question. Public expectations might be slightly different at the end of the pandemic. I believe that the public have always perceived hospitals as being extremely safe places. Although we have driven the patient safety agenda, there are inherent risks in any sort of surgery or exposure to radiation and so on, and that is before you start talking about the organisms that we have to deal with.

Hopefully, we can start to have a sensible conversation about how we reduce demand and promote health rather than just treat ill health. One of the positive things that have come to the fore during the pandemic is the fact that we are seeing more people exercising, cycling and so on, which might be good for the nation. However, we are going to have to be honest and say that it will be a challenge to get waiting times back to appropriate levels. That will take a significant amount of time and I would have thought that, given the impact of the pandemic on the economy, limited finances will be available to support that.

Brian Whittle: Just as a quick aside, what is the situation with hospital bed occupancy compared with pre-Covid levels?

Calum Campbell: We saw a massive reduction in attendances in our accident and emergency departments at the start of the pandemic. On an average day at that time, the A and E unit at the Royal infirmary of Edinburgh might have had between 260 or 270 to 330 or 340 admissions, but there might also be quieter days. Yesterday, however, we had 407.

The reality is that the sector is already under pressure this autumn and we will have to plan for winter. People have started to come back, but much of that is related to urgent care and accounts for some of the backlog to which Brian Whittle referred.

Brian Whittle: Did we strike the right balance during lockdown between minimising the direct health impacts and the indirect health impacts, given that, as you said, we have a backlog that will not go away and will have to be dealt with at some point? We are looking at Covid because it is right in front of our faces and we can measure that right here, right now, but have we dealt with the backlog that is coming down the road?

Calum Campbell: That is an important question. History will judge us. In Lothian we can say that we moved in line with national guidance. At the time, the evidence was limited and I do not think that anybody acted in bad faith. However, I am sure that there will be lessons that we can learn and pick things up from. However, at this point I would not want to criticise the approach.

Brian Whittle: Just to clarify, I am making no criticism. I was trying to grab a bit of reality and look back at decisions that have been made—which were all made in good faith at the time—to see whether we could do anything different in the future.

Is there a timescale for a recovery to pre-Covid levels of performance or is the reality that we are unlikely ever to get there?

Calum Campbell: The timeline is very difficult. We thought that we were coming out of the first peak and that there might be a second wave—there still might be a second wave and we are seeing a wee bit more demand. Until we have a vaccine, how can we say how long this will go on? I really do not know. It is impossible to say how long it is going to last.

I suggest that it is highly unlikely that we will get back to pre-Covid levels. One of the lessons that we can take from this is the importance of single rooms in hospitals. I am conscious that you heard from NHS Greater Glasgow and Clyde earlier on and that Dumfries and Galloway Royal infirmary has single rooms. In Lothian, we have a limited number of single rooms. I would be astounded if there were not to be an increased focus on single room accommodation. Something that we must take from the pandemic is that it was much easier to cohort patients who were in single rooms.

Brian Whittle: Thank you.

David Torrance: How has the demand on hospices been affected by the pandemic?

Calum Campbell: I will start by giving an example from Lanarkshire before asking Susan Goldsmith to speak about Lothian. In Lanarkshire at the start of the pandemic we saw a slight decrease in demand for the hospices. The Kilbryde Hospice was absolutely superb and made its facilities available to NHS Lanarkshire. It was part of our surge response and we used it in the rise of the first wave.

Susan Goldsmith: I am not able to answer the question on the current demand, but I know that we agreed funding of £2 million to support the hospices, which was made available to the hospices.

David Torrance: Is it anticipated that following a reduction of client care and diagnostic testing during the pandemic, future demand for hospice care will increase? If so, how will that be funded?

Calum Campbell: As that is a funding question, I will duck it and pass it to my director of finance.

Susan Goldsmith: Through our financial planning process we are always looking at future demand and trying to ensure that we provide for it. The discussions and dialogue that we have with hospices have featured in that financial planning process over many years.

We work in partnership with our hospices. If there was to be future demand on hospices, it would be in the interests of our wider system that we work with them to ensure that they had the right capacity in place for that demand. We will continue to work with them in the coming years, if that comes to pass.

David Torrance: What other services that are commissioned by the IJBs have received increased funding as a result of the pandemic? Is it anticipated that the extra funding will need to be continued?

Susan Goldsmith: We have transferred funding to the integration joint boards for social care, and for primary care and hospice funding. We are working with the IJBs on the assessment of the impact on social care, and we understand that further funding will be coming. That is part of our wider assessment of the resource impacts not just on the board but on social care. How that translates into the future partly relates to what future models of care will look like and what capacity will be required across the system. We work on that with our IJBs through the financial planning process.

Sandra White: My questions are similar to the ones that I asked the NHS Greater Glasgow and Clyde witnesses about new technology and innovation. What innovations have you used during the lockdown and will they be retained or extended after Covid-19?

Calum Campbell: We have used Near Me, which has great potential. To give a specific example, which I discussed yesterday, we can use that increasingly in nursing homes. As people move into nursing homes, we want to maintain them there if possible instead of bringing them in and out of the acute sector. However, all clinical services have an opportunity to use Near Me.

We are increasingly using remote monitoring, which reduces the need for some patients to come to hospital.

The biggest one, however, is Microsoft Teams. Throughout the pandemic, we have seen a transformation in the way that our corporate services operate. Large numbers of our payroll, human resources and finance staff have been working from home throughout the period, which has been a revelation. If you had asked me six or nine months ago whether that was possible, I would have said no.

As well as being chief executive of NHS Lothian, I chair the Scottish terms and conditions committee, as the employer chair, and I know that staff-side colleagues are keen to have conversations about what that means for home-working policies and so on. That is something that will come out of the current situation.

Sandra White: That is interesting and useful. The NHS Greater Glasgow and Clyde witnesses mentioned the call-in facility for doctors, which is

used in health boards and IJBs. Have you explored that new technology and innovation?

Calum Campbell: Are you referring to the consultant connect system, which is between consultants and GPs?

Sandra White: Yes.

Calum Campbell: The answer is yes.

Sandra White: So you have used that system, and there has been a lot of innovation on the staff side, but have you found any barriers to digital care? Has the infrastructure broken down or has it been working all right?

Calum Campbell: There is a challenge. Anything new brings challenges, and some of us are not getting any younger, so we are sometimes dependent on others to help us to set up the technology.

To go back to your earlier point, I focused on the corporate staff example, but the examples that we have had in Lothian have related as much to clinical staff as to corporate staff.

One of the biggest barriers that all health boards will have to think about is the fact that we will have to spend more money on information technology and Teams technology, and we will also have to be very careful around digital exclusion. As we invest in the health service, we have to be aware that we do not drive inequalities in a different way.

11:45

Sandra White: Absolutely. I agree with that. Earlier, you said that in your previous brief in NHS Lanarkshire, you could always contact local council chief executives and that kind of thing. Will you look at evaluating patients' experience of this new technology? Will you produce a paper or will you ask patients how they have felt about it?

Calum Campbell: Yes, and the evaluation will have to be more than just at the NHS Lothian level. We should be looking at this issue nationally. You will expect us to be as efficient as possible and, if we are going to use technology, we are better using it at regional or national scale to drive the biggest benefits, and to give us as much flexibility and standardisation as possible, so that it is not confusing for patients who move between health boards. I would be happy to share all our feedback on that.

Sandra White: My final question is on the same theme. Will you also evaluate the interventions from the new technology that we have been talking about, or assess the value that it has brought to the patients and the health board?

Calum Campbell: Susan Goldsmith is probably best placed to answer that.

Susan Goldsmith: One of the things that we are absolutely clear about is that every case that comes forward for further investment should define the benefits. For example, we have just considered a case of how much more efficient community nurses who work in children services can be by not having to keep going back to base in health centres to log in to a machine there. Every single case will have different benefits either in terms of reduced travel, or more patients, and we will also have to do some qualitative assessment. The answer to Sandra White's question is yes.

Donald Cameron: My questions are about a potential second wave of the virus, which is of course difficult to predict, although it is on all our minds. What planning has NHS Lothian put in place to ensure that the board will be able to deal with a future increase in the number of Covid-19 cases?

Calum Campbell: The lessons that we have learned from the first response, especially around doubling and tripling our ITU capacity, are sitting there, in place. We now have the benefit of the national clinical prioritisation tool, and we will continue to see urgent patients. Our communications to the public, and their understanding of the disease and the things that we have to do to mitigate it, are all in place. We are also putting a significant focus on some of our unscheduled care—I gave the example of "call MIA", which is a video platform for minor injuries.

All those things are ready to roll out should we have a second wave.

Donald Cameron: You answered this partially by detailing what you are doing to ensure that other clinical activity can continue. Can you just confirm that you have a plan in place to deal with urgent or elective cases, notwithstanding a second surge?

Calum Campbell: Of course, but I would expect that our capacity would be stretched so we would have to use the clinical prioritisation tool to try to keep urgent and cancer cases going. However, that will be based on clinical priority.

The Convener: Thank you. Does Donald Cameron have another question?

Donald Cameron: I have one more, on testing, which is very much in the news at the moment. What is the board doing in respect of testing? I am particularly interested in learning how many tests you are carrying out per day and what your testing capacity is.

Calum Campbell: We have enhanced our labs—they are operating seven days a week, on extended hours. There is a relatively small team. We can do approximately 3,300 tests a day; we

were not at that capacity previously, but we are now doing 1,000 tests a day for care homes, to take some of the pressure off there. However, that will not be sustainable if we continue to see a rise in activity in the acute sector. We are certainly offering that support in the short term.

David Stewart: The report, "Lessons Learned From Reducing Delayed Discharges And Hospital Admissions", notes that a partnership said that, during the pandemic,

"medical staff were leaving social decisions to social care teams".

Was that what led to a reduction in delayed discharge?

Calum Campbell: That should happen anyway. The clinical staff should assess whether someone is clinically fit and the social care staff should engage with the patient and their family to work out the most appropriate setting for the person to go to, with the preference being that they should go back home if at all possible. I am not sure that I agree that there is a magic bullet in addressing the challenge that we have had with delayed discharges.

David Stewart: How can reduced delayed discharge levels be sustained? Is ingrained behaviour as important as finance?

Calum Campbell: A positive of the pandemic is that we have seen a significant reduction in delayed discharges, although they are rising a wee bit just now, which is a concern. We need to try to strike a balance between the capacity in the acute sector and the capacity in nursing homes, residential homes and care at home. That has to be the answer. Finance is an issue, but we need to get capacity right in each of those areas.

David Stewart: Have you assessed the costs and benefits of reducing delayed discharge?

Susan Goldsmith: I confirm that, as Mark White said, there is a significant differential between the cost of care in acute hospital services and the cost of care at home or in the community—I think that he said that care in the community comes in at about a quarter of the cost, which is about right. However, we try to make sure that discussions about the balance of care are not driven by cost. It is important that we make sure that we have the right capacity in the right place.

The Convener: A number of members still have questions. I encourage them to be succinct—sorry, I see that David Stewart has not finished yet.

David Stewart: Thank you, convener.

The final area that I want to look at is health inequalities. I note that there was a recent board paper on the subject. What work has been undertaken to evaluate the impact on health inequalities of decisions that were taken during the pandemic?

Calum Campbell: It is a bit early to give a definitive answer, but the focus and the drive behind your question are 100 per cent right. We will try—with all our board papers and certainly as we look at our service models—to look at the situation through the lens of health inequalities and consider whether we can do anything to reduce them.

A concern that I think that many of us have, which relates to the question that I asked earlier, is whether history will judge us badly over this. Have we potentially made health inequalities greater? We need to accept that question and see what we can do about the issue.

David Stewart: The chief executive has partially covered my final question. What consideration is being given to addressing health inequalities in the remobilisation plan?

Calum Campbell: The remobilisation plan will try to do much of what I said earlier. We will have to look at any new models of service and whether they have any unintended consequences. The point about digital exclusion is a very good example. Another example is that, even if people have access to digital—[*Inaudible*.]—we could do something about transportation. We will have to look at everything in the round and find the best balance.

Emma Harper: Before I ask my final questions about mental health services, including child and adolescent mental health services, I want to follow up on Brian Whittle's questions and ask about restarting total hip and knee replacement procedures. Additional planning and organising are being done. There are key requirements, and the provision of single rooms is a great example of what works really well when restarting hip and knee replacements. Will there be a significant impact or an increase in costs from restarting elective orthopaedic surgery? I remind colleagues that I am a former perioperative nurse, and orthopaedics was one of my favourite theatres to work in, so I am interested in the cost impacts of restarting elective total hip and knee replacements. How you will get on top of the backlog?

Calum Campbell: Elective surgeries—even surgery as significant as total knee and hip replacements—are not emergencies. However, if someone is suffering from severe pain, that will affect their life and will be of crucial importance to them. We need to keep the pathways as green as possible, and we were struggling with capacity before the pandemic.

I go back to the point that Susan Goldsmith made. We will have to see whether we can work with the independent sector to increase our capacity, because, although I accept that such elective surgery is not clinically urgent in a major way, its impact on somebody's life can be massive. We need to find a solution to that, but it will come at an increased cost.

Emma Harper: We will need to think about how we support people to have their pain managed appropriately. Mobility is obviously crucial for people who are waiting for hip and knee replacements.

I have a couple of questions about child and adolescent mental health. Services were available during the pandemic. Will you highlight which services have been available to children and young people with mental health problems during the pandemic? What impact has Covid-19 had on waiting times for child and adolescent mental health services?

Calum Campbell: Going into the pandemic, one of the challenging areas for NHS Lothian was the child and adolescent mental health service. [*Interruption*.] I am repeating the odd word because the headphones are giving me a bit of feedback.

The service responded by following up with many patients using technology, and it has performed well in that area. It is disappointing, though, that the waiting time is much greater than we would like. We are engaging with the service. We have invested more than £3 million of additional funding into CAMHS in order to increase our capacity. We are exploring why we cannot use technology more to do some of the initial assessments, especially in the light of the fact that there is no guarantee that we will not have a second wave. The service is one of the board's key priorities, but it is not an area of strength for us at this time.

Emma Harper: Do you anticipate an increase in demand for mental health services, not just for children and adolescents but across the board? Obviously, planning for that needs to be part of the work that is taken forward.

12:00

Calum Campbell: Absolutely. Our mental health service has been really good at helping us with unscheduled care. We have created a mental health hub and we are looking to see what more we can do with it. You talked about areas of additional demand. Mental health services, for adults and children, will be under significant pressure as a result of the impacts of Covid.

Emma Harper: I have one final question. We have community hub development and many other ways of engaging people using virtual technology, which has been really good for mental health services. Can you provide an update on the development of mental health assessment centres?

Calum Campbell: In Edinburgh, we have brought the mental health services together to try to ensure that any unscheduled mental health attendances go there, via NHS 24. We are creating a flow hub in NHS Lothian to direct staff to direct patients there. When people turn up at an accident and emergency department with a mental health problem and there is no associated physical health issue such as an overdose, we are starting to move them across to the mental health assessment unit to try to give them the best possible care. We take them away from the A and E department, which is rarely the best place for them. We will see how we can share that model and contrast it with the Glasgow model. We have started conversations with NHS Lanarkshire to try to get the benefits of working with each other right across the central belt.

Brian Whittle: My question follows on from my previous one, and is on my pet topic of preventative health measures. You have discussed how we create a service that prevents people from becoming increasingly unhealthy. In the current climate and in light of the pandemic, what steps is the board taking to support the health of the population through prevention?

Calum Campbell: The immediate one relates to the flu. We are talking about Covid, but flu is a massive killer every year and, to a degree, as a country, we have got a wee bit blasé about it. All senior politicians, health service managers and clinicians have a duty to communicate clearly to the population that the biggest help that they can give us this winter is to get the flu vaccine. Obviously, we are also planning for the Covid vaccine.

The Scottish Parliament has done lots of good stuff on smoking and alcohol. I suppose that my feedback to the Parliament is that we require similar assistance and a focus on health as much as ill-health if we are going to make a transformational change in the health of the population.

Brian Whittle: We all talk about preventative health measures that can be taken. That is the direction of travel, and we talk about obesity, diabetes and whatnot. Covid has brought that into sharp focus, in that the mortality rate is very much linked to obesity, diabetes and other conditions. However, has the pandemic taken focus away from preventative measures? That would be understandable, because the pandemic is right in

front of our faces, but have we, as parliamentarians and the health service, lost focus on the preventative agenda?

Calum Campbell: The honest answer is that I am not sure. At the end of this, we should all reflect on the position that we went into it from as a nation. I am not too sure that we benchmarked particularly well in a preventative health sense, so we should reflect on that.

The evidence suggests that the three biggest drivers of Covid are age, obesity and gender, which cover a large percentage of the population. It has been a bit of motivation for people to do something about their health but I am not sure how to sustain that. That is one of the killer questions for us: how do we help those who have made lifestyle changes to sustain them, without forgetting how difficult this year has been?

Brian Whittle: I absolutely agree with you. How do we grab a hold of the changes that have been made and make them sustainable?

To follow on from that, what is the latest estimate of the additional costs for NHS Lothian and the health and social care partnerships resulting from Covid-19?

Susan Goldsmith: The health and social care and local authority partnerships are still working through that. However, the estimate that we submitted in August showed that we expect the additional cost to be approximately £37 million to £38 million for social care and some elements of the partnership. We think that that might be a bit of an underestimate, so we are looking at it again—we should conclude that later this week.

David Torrance: What impact has Covid-19 had on existing workforce pressures?

Calum Campbell: We have brought 1,100 additional staff into NHS Lothian. They are predominantly nursing staff, domestics and porters. We will have to wait and see how long this continues to see whether we can sustain that.

David Torrance: My next question follows on from that. Why has NHS Lothian had such high temporary staff costs? What action could be taken to reduce temporary staff costs?

Calum Campbell: I will ask Susan Goldsmith to give you some detail on that. Historically in Lothian, we have struggled to recruit in certain areas, so we have had to bring in agency staff and so on. However, when we can get permanent staff who are appropriately qualified, that is the cheapest model for us to use.

Susan Goldsmith: I would not necessarily see temporary staff as a negative thing. We have a successful bank from where we bring in people who want to work flexibly. That model has worked well for us for a number of years, during which we have seen turnover because we are in a relatively competitive market. It has also allowed us to minimise our use of agency staff.

It is clearly best to have permanent staff in post whenever possible, but the bank resource allows us to flex and to cover sickness and absence when there are pockets of higher levels. There are therefore positives to the temporary staffing arrangements that we have in place.

David Torrance: What steps have been taken to ensure that NHS Lothian has a flexible workforce that would be able to meet demand if there was a future increase in Covid-19 admissions?

Calum Campbell: My answer to that is similar to my previous answer. We have to increase the number of domestics and look at how we can rapidly expand our testing and tracing capacity. We also have to look at how to expand our lab capacity. Those are the key areas of workforce planning that we are going to have to take forward during the next six months.

The Convener: I thank Calum Campbell and Susan Goldsmith for their evidence today. It has been helpful and I am sure that we will follow it up with one or two more questions after the meeting.

12:10

Meeting continued in private until 12:29.

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