OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 22 September 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 22 September 2020

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HEALTH AND SPORT COMMITTEE
24th 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:

Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing)
Richard McCallum (Scottish Government)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 22 September 2020

[The Convener opened the meeting at 10:30]

European Union (Withdrawal) Act 2018

Reciprocal and Cross-Border Healthcare (Amendment etc) (EU Exit) Regulations 2020

The Convener (Lewis Macdonald): Good morning, and welcome to the 24th meeting of the Health and Sport Committee in 2020. We have received apologies from Alex Cole-Hamilton.

Item 1 is consideration of four consent notifications that propose that the Scottish Government give consent to the United Kingdom Government to legislate, using the powers in the European Union (Withdrawal) Act 2018, through a number of UK statutory instruments.

The first consent notification that we will consider relates to the Reciprocal and Cross-Border Healthcare (Amendment etc) (EU Exit) Regulations 2020. I invite comments from members.

Sandra White (Glasgow Kelvin) (SNP): Thank you, convener. On page 4 of our paper on the consent notification, in paragraph 20(b) it is recommended that if the committee approves the giving of consent, it

"use the letter confirming approval to request that it is kept updated on the Scottish Government's role in negotiations as detailed above"—

in paragraph 19 of the paper, where it says that the committee might ask to be

"kept updated on the Scottish Government's role in negotiations between the UK and the EU on the future status of citizens' rights to healthcare and to social security benefits. In particular, the Committee could ask what progress is being made in relation to the rights Scottish citizens will have if they fall ill while travelling, living and/or ... working abroad in an EU country after 31 December."

I think that it is important that we take up the recommendation in paragraph 20(b) and make that request, so that we can keep an eye on the issue.

The Convener: Thank you. No other member wants to comment. If we are content with the giving of consent, we can also—as Sandra White said—ask to be kept up to date on the negotiations, in our letter confirming that.

Are members content for the Scottish Government to give its consent for UK ministers to lay the statutory instrument in the UK Parliament, and if so, also to use the letter that will confirm approval in the way that has been described? No member has said that they are not content.

Nutrition (Amendment etc) EU Exit Regulations 2020

The Convener: We move to the second consent notification. I invite comments from members.

Members have no comments on the regulations—

I apologise; I missed Sandra White.

Sandra White: My comments will touch on the Northern Ireland protocol; I seek clarification on a number of issues in that respect. Is the Northern Ireland protocol deemed to be akin to EU regulations? Through the regulations, "UK" is to be taken out of regulations and "Great Britain" put in. I could go through each regulation, but I do not want to go on for too long. My reading is that the Northern Ireland protocol appears to be more akin to the European Union approach, which is why Northern Ireland is being taken out of the regulations. Is that correct?

The Convener: Yes. I think that the human tissue regulations to which we will come have more focus on the Northern Ireland protocol.

The regulations will, as will all the regulations that we are considering today, put in place arrangements under the withdrawal agreement—in other words, the treaty that has been agreed between the United Kingdom and the European Union. The regulations will allow Northern Ireland to continue to operate within the scope of EU regulations. Slightly different approaches by Northern Ireland and Great Britain are required.

Sandra White: The Minister for Public Health, Sport and Wellbeing's letter on the regulations states:

"It is our unwelcome responsibility to ensure that devolved law continues to function".

The letter also says:

"Please note, we are yet to have sight of the final SI",

which is not available in the public domain. I am a bit concerned that we have not seen the SI but have, like the Scottish Government, no option but to recommend that we agree to it.

Rather than go through every paragraph, the last issue that I will raise is—I thank the convener for clarifying this—the situation whereby Northern Ireland rules and regulations are more akin to the EU's, which is why Northern Ireland is being taken

out of the regulations. That is rather strange, however, given that Northern Ireland is supposed to be part of the UK.

Does the change mean that goods that come from Northern Ireland to Great Britain will be treated as imports but goods going from Scotland, or "GB", to Northern Ireland will be subject to EU law and not treated as imports? I think that that question will also apply to the Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations 2020 and the Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations 2020.

The Convener: That broadly describes the position, but the situation is complex, as you say. The point about having sight of the statutory instrument is important, though. I recommend to the committee that we agree to the Scottish Government going ahead with the nutrition regulations but express in writing to the Government that we would welcome sight of the SI when it is available.

This will clearly be a common experience, as it has been already, in the process of EU exit and withdrawal legislation, because it is often being done at a pace that means that SIs are not always seen in line with the usual parliamentary requirements. However, how Sandra White has described the relationship between Northern Ireland and Great Britain is the case.

Sandra White: Thank you for that clarification. I presume that that is to prevent a hard border between Northern Ireland and Eire. With Brexit looming, it is important that that is mentioned.

The Convener: That is correct, and I hope that that clarifies matters. As I said, some of the issues that Sandra White raised perhaps have greater applicability to the next instrument that we will come to.

However, in relation to the Nutrition (Amendment etc) EU Exit Regulations 2020, the question is whether the committee is content to approve the Scottish Government giving its consent to UK ministers laying an SI in the UK Parliament on the subject and, in confirming that, to express that we would welcome sight of the SI when it is available. No member disagrees, so the committee is content to do that.

Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations 2020

Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations 2020

Blood Safety and Quality (Amendment) (EU Exit) Regulations 2020

The Convener: The third consent notification is in relation to three instruments, as indicated on the agenda. I invite comments from members.

Emma Harper (South Scotland) (SNP): Paragraph 3 of our papers says:

> "The effect of the amendments will be that where donated human organs, tissues and cells, and blood move from Northern Ireland to Great Britain, they will not be treated as imports. Conversely however, when these are sent from Great Britain to Northern Ireland, they will need to be treated as imports".

It is obviously disappointing that we are leaving the EU. I worry that the regulations will increase complexity because—as a former liver transplant nurse—I worry that there will be delays. We cannot have delays in organ and tissue transplantation; a heart, for example, can stay on ice for only four hours. It is a real challenge, so we need to ensure that no delays are incurred as a result of any of the regulations that are to be put in place. I seek assurance about that.

The Convener: That is reasonable. Brian Whittle also has a point to make.

Brian Whittle (South Scotland) (Con): It is my understanding that one of the reasons for potential disparity is that there are differences between the UK and Northern Ireland because there are devolved health services within the UK. Is that one of the reasons why things seem to go one way here?

The Convener: I am no expert on the details, but my sense is that that is not particularly the case. The regulations that we are considering today in the context of Scotland are a variant of regulations that will apply in the context of England. The difference in definition is between Great Britain on the one hand, and Northern Ireland on the other. As Emma Harper said, the difference is fundamentally to protect Northern Ireland's position, and access for Northern Irish citizens.

Brian Whittle: The committee has looked at organ donation, and the Scottish Government and Parliament have changed how we can access transplants. As things stand, organs can move around Great Britain freely. Is that changing for Northern Ireland? Is that what we are saying?

The Convener: No—but the legislation creates a framework within which change could happen, in due course. That would be cause for concern, as Emma Harper has described, if it had consequences for the transplant process in Northern Ireland, or in Scotland or elsewhere in GB. That is something that we should address in making a decision.

Sandra White: Emma Harper's point is valid. As far as I know, the Northern Ireland protocol is a protocol for the Northern Irish alone and is more akin to European law, which is why regulations' wording is being changed from "UK" to "GB"—meaning England, Scotland and Wales. The regulations also mention specifically that any organ transplant going from GB will be subject to EU protocols, but organs being sent from Northern Ireland to Great Britain will just be treated as imports.

There are implications for the length of time transportation takes, and for whether there are any charges and so on. That is my understanding. The regulations are simply because of Brexit and making sure that there is no hard border on Ireland. That is what it is all about.

The Convener: That is absolutely right. That describes the situation well. We are in very unusual circumstances and my reading is that, in laying the instrument, the Scottish Government is seeking to protect the position of people who might wish to receive or donate in relation to transplants between Scotland and Northern Ireland.

The wider treaty between the UK and the EU protects Northern Ireland's access—or membership if you like—subject to the rules of the single market. That is a political agreement that has been reached between the UK and the European Union.

10:45

To go back to Brian Whittle's point, I say that it is possible that we could end up with four different sets of regulations applying in the four nations of the United Kingdom.

Emma Harper: I would like to raise a point about organ and tissue transplantation. The traceability, tracking and following of organs and tissues are crucial when we are working with patients and trying to ensure that the right organ gets to the right person. Brexit is not a job done; it has caused many issues. We must ensure that the safety of everyone involved is continued when we look at changing the regulations.

The Convener: That is my view and, based on the comments that we have heard from Sandra White and Brian Whittle, the committee also believes that protecting organ donation is a priority. The committee has done significant work on that in the past year or two—for example, on ensuring that traceability is maintained and that there is freedom of movement for vital and time-dependent organs.

Although that is a matter of concern for the committee, I do not think that I have heard anyone suggest that we should not signal our approval for the Scottish Government to proceed. That would mean that we would consent to UK ministers laying a statutory instrument on the subject in the UK Parliament.

Are members of the committee content with that, subject to our sending a letter asking for confirmation on a number of issues? It seems that members are content.

I suggest that the letter include a request that we be kept up to date on the Scottish Government's engagement with the UK Government on the Northern Ireland protocol. We should also ask what procedure would apply if there were to be any future divergence in the applicable standards between Northern Ireland and Great Britain, and we should ask for an assurance that the Scottish Government is approaching the matter in a way that will ensure that there is no delay in the organ transplant process and no impact on traceability in organ transplants.

Does any member disagree that those points should go into the letter? We are content. Thank you.

The fourth and final consent notification is on two sets of regulations: the European Qualifications (Health and Social Care Professions) (EFTA States) (Amendment etc) (EU Exit) Regulations 2020, and the Professional Qualifications and Services (Amendments and Miscellaneous Provisions) (EU Exit) Regulations 2020.

Members have no comments, so is the committee content for the Scottish Government to give its consent to UK ministers laying a statutory instrument in the UK Parliament on the subject?. No member disagrees.

Subordinate Legislation

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 13) Regulations 2020 (SSI 2020/274)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 14) Regulations 2020 (SSI 2020/280)

10:48

The Convener: Agenda item 2 is consideration of two made affirmative instruments. As in previous meetings, these instruments relate to the coronavirus and international travel and are laid under section 94(1) of the Public Health etc (Scotland) Act 2008, which concerns international travel.

Such regulations should be subject to affirmative procedure. When such regulations must be made urgently, they can be made by the Scottish ministers but must then be brought before the Scottish Parliament within a period of 28 days, beginning with the day on which the regulations were made. It is for the Health and Sport Committee to consider the instruments and to report to Parliament accordingly, within that 28-day window.

The Convener: I welcome to the committee Humza Yousaf, the Cabinet Secretary for Justice, and accompanying Scottish Government officials Rachel Sunderland, who is deputy director in the population and migration division; Jamie MacDougall, who is deputy director in the test and protect portfolio; and Anita Popplestone, who is head of police complaints and scrutiny.

I propose that, with the agreement of the cabinet secretary and members, we take the two sets of regulations as one item. Any questions to the cabinet secretary may deal with both and we will hold the formal debate on both together.

I will start and will then invite other members to speak. When the cabinet secretary last appeared before the committee, we discussed the publication of numbers and increasing transparency about the quarantine regulations and their application. Does the cabinet secretary have anything additional that he wishes to draw to the committee's attention on that?

The Cabinet Secretary for Justice (Humza Yousaf): Good morning. I hope that members are keeping well and safe.

I thank the convener for his question. If he had not asked, I would have proactively mentioned that, in previous committee sessions, I referenced the fact that the number of people who have tested positive and have a link to international travel would be published by Public Health Scotland on 23 September. I have been given a note today, and I am more than happy to expand on it in writing, saying that the publication of that has been delayed. It should not be a long delay, but Public Health Scotland has concerns about the quality of the data and it needs to do some assurance work on it. I have been told that it is working to resolve the issue so that the numbers can be published. There will be a call between officials and Public Health Scotland to discuss the detail.

At the moment, the intention is to publish the figures. As I previously indicated, they will not be published on 23 September, but I have been told that the delay will not be a long one. I apologise for that. I would have liked to have the figures to hand on 23 September, but they will be delayed.

The Convener: Thank you. It is clearly disappointing that there is a delay, but it is good to have the cabinet secretary's assurance.

Emma Harper: Constituents have asked me whether people travelling into Scotland should be accessing or downloading the Protect Scotland app? Could the Scottish Government shed light on whether we are encouraging people to download that app?

Humza Yousaf: The short answer is yes. If you download the app and turn on the Bluetooth and location functions, it will let you know about contact. Even if you are in the country for a few days or a few weeks on holiday, it is still absolutely advisable.

Emma Harper makes a good point. With my health colleagues, I will look to see whether we can do more at the ports of entry to ensure that people know to download the app. I know that there is an advertising campaign on the test and protect app, but I will double check with the Cabinet Secretary for Health and Sport and the Cabinet Secretary for Transport whether we need to do more at the points of entry.

The Convener: Members have no further questions, so we will move on to the next agenda item, which is the formal debate on the instruments. As I have said, I propose to take the two instruments together. Are members agreed?

I see agreement that we should do so. In that case, I remind members that this is a formal debate, so there will no longer be questions, but there may of course be contributions.

I invite the cabinet secretary to speak to and move motions S5M-22634 and S5M-22705, in his name.

Humza Yousaf: I know how packed your agenda is so, as in previous weeks, I am happy to waive my right to speak on the motions.

Motions moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 13) Regulations 2020 (SSI 2020/274) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 14) Regulations 2020 (SSI 2020/280) be approved.—[*Humza Yousaf*]

Motions agreed to.

The Convener: We will report to Parliament accordingly. I thank the cabinet secretary and his officials for attending and for once again being available to answer questions on the regulations. I have no doubt that we will see you all again before too long, as this is an ever-changing scene. No doubt we will hear more as we go forward.

Pre-Budget Scrutiny 2021-22

10:56

The Convener: The fifth item on our agenda is an evidence session on the budget for 2021-22. Our approach to scrutiny of the budget reflects the approach that was recommended by the budget process review group. We have undertaken evidence sessions with a number of interested parties that are involved in the health and sport budget, and today we will hear from the Scottish Government. I am happy to welcome to the committee Joe FitzPatrick, Minister for Public Health, Sport and Wellbeing, and Richard McCallum, interim director of health finance and governance at the Scottish Government.

I invite the minister to make a brief opening statement.

The Minister for Public Health, Sport and Wellbeing (Joe FitzPatrick): Good morning. I thank the committee for its forbearance in relation to the changes to this meeting. Clearly, we are in fast-moving times and I am sure that the committee is aware that the Cabinet Secretary for Health and Sport is otherwise engaged. However, for the record, we heard during the weekend that there would be a COBRA meeting and, yesterday afternoon, that was confirmed for this morning. It will be followed by a meeting of the Scottish Government's Cabinet to confirm our response to the current coronavirus developments in advance of the First Minister's statement to Parliament this afternoon, which is of course subject to the agreement of the Parliamentary Bureau, which I think will meet around noon.

I am pleased to stand in for the cabinet secretary. I will take a few moments to set out some reflections on the health and social care response to Covid-19. I will outline the key considerations that have underpinned our approach so far and, in view of the primary concern of the committee for this evidence session, I will highlight the high standards of stewardship that we have maintained throughout.

The committee will be well aware of the scale of the challenge across our public services and the level of uncertainty that we face. In that context, it gives me particular pride to reflect on the ways in which our front-line national health service and social care workforce, and all those working to support them, have responded so heroically throughout the pandemic. We owe them a significant debt of gratitude.

On the key developments in the past few months, with NHS 24 as the key point of contact, community hub and assessment centres have provided wide-scale triage of patients with

symptoms away from general practitioner practices and out-of-hours services towards assessment centres that have been established exclusively to respond to patients with expected Covid-19.

Between 23 March and 2 September, around 115,000 individuals were seen, with more than 140,000 consultations through the community hubs and assessment centres. We have developed our digital solutions, such as the Near Me video consulting service, on which we condensed work that we had been planning as a two-year programme of change into just six weeks. The Near Me service is now embedded in the way in which a large number of services provide patient-centred care and it will have long-lasting benefits beyond Covid, reducing the need for people to travel and take time off work for appointments.

11:00

Between 1 March and 8 September, more than 297 million items of personal protective equipment were delivered to hospitals across Scotland. In addition, 129 million items were distributed to social care organisations and 41 million for community care. We are now undertaking detailed winter planning to ensure that supply meets demand.

To support the necessary decisions on Covid-19, we immediately put in place arrangements across NHS boards, integration authorities and the Scottish Government to ensure tight control of spend and to maintain the highest standards of stewardship. That included implementing a revised framework for rapid and effective decision making across the sector, while continuing to ensure overall ministerial responsibility.

Officials are concluding our detailed quarter 1 review of expenditure. Once we have had the opportunity to review that in detail, we will provide further funding across the sector for costs that have been incurred to date and to support on-going activity and remobilisation over the coming months. We will be happy to share further details with the committee in due course.

As we look to the months and years ahead, we are taking forward initiatives to continue to develop a world-class public health service that builds on our Covid-19 response. As set out in the programme for government, the most significant economic and social policy of the coming parliamentary year will be our commitment to testing, contact tracing and surveillance and response. As the First Minister has set out, central to that will be continuing to suppress the virus, building on the early success of our work on surveillance and response and on NHS test and protect, as we continue to remobilise the health service. That will be supported by our new proximity tracing app, Protect Scotland.

In preparing for winter pressures and to protect people and our NHS this winter, we will extend access to the seasonal flu vaccine to those working in social care who provide direct personal care, to those over 55, to those living with someone who is in the shielding group and, depending on vaccine supplies, to those aged 50 to 54. That is in addition to the existing cohorts who are ordinarily given the flu vaccine.

As set out in the programme for government, we will establish community health and wellbeing services that will support children, young people and their families, and which will have a particular focus on mental health, across all local authorities in 2021. We will work with boards to retain, develop and support mental health assessment centres as part of a broader approach to improving access to appropriate help as quickly as possible for people with mental health needs or distress.

Alongside our investment in mental health, we will continue our work to deliver our priorities for social care and primary care reforms, shifting the overall balance of care towards community health services.

I am happy to discuss any of those areas with the committee.

The Convener: Thank you very much. The committee is very grateful to Mr FitzPatrick for stepping in at short notice to take the place of the cabinet secretary. We have a lot of territory to cover, and I know that the minister will be keen to address the questions that members ask.

Without further ado, I will bring the focus firmly on to budgetary aspects. What additional sums are expected to be allocated to the health budget in this financial year, over and above the £620 million that was identified in the summer budget revision? Does the Scottish Government plan to allocate additional resources beyond those that have been received through health-related Barnett consequentials?

Joe FitzPatrick: Members will be aware that the autumn budget revision is due to be published this week, on Thursday 24 September. I can reveal to the committee that the revision will confirm £2.5 billion of additional health and social care consequentials for the health portfolio. In relation to additional resources over and above that, there are clearly significant uncertainties in the forecasts from NHS boards and integration joint boards, in particular, about the implications relating to winter, a second wave, PPE and social care. A huge amount of work is progressing at pace on our assessment of financial implications in order to ensure that we continue to provide the

necessary funding for our front-line healthcare services.

The Convener: I have no doubt that we will hear more about that work in due course. Clearly, one of the consequences of the Covid crisis has been less activity in other areas of health and care, as resources have inevitably been targeted on the most immediate and urgent priorities. Can the minister offer any estimate of how much may have been redirected from elsewhere in the health budget as a result of those reduced levels of activity? Where was it redirected from?

Joe FitzPatrick: Clearly, one of the unfortunate aspects of Covid is that work that we would have hoped could progress has had to be paused. We would expect boards to have a level of savings as a result of activity that has not been taken forward. We are still working through that with boards in advance of agreeing funding for over the winter. It would therefore probably be too much of a guess if I were to give any sort of a figure.

The Convener: Looking beyond the winter and the current financial year, Covid-19 will clearly have implications for the 2021-22 budget. In addition to that, the objective of our pre-budget scrutiny is, fundamentally, to consider that year's budget. Does the Government currently have any view as to whether additional resources will be required and, if so, to what extent?

Joe FitzPatrick: Obviously, one of the big parts of the jigsaw is UK funding, which has not yet been confirmed beyond this year. That is an essential part of the picture that we require. However, we expect the Chancellor of the Exchequer to deliver in full on his commitment that the NHS will receive whatever funding it requires.

When it comes to the implications for the 2021-22 budget, there will need to be an assessment of the recurring implications of the spend that has been committed this year, for example on additional packages of community care, additional hospital beds, community hubs, and information technology investment. We need to understand what will be recurring and what will have been one-off spend. A huge amount of work is going on with NHS boards and IJBs to assess those details, which will help us to form a clearer picture of what support is required.

Emma Harper: Good morning, minister. I have a couple of questions about NHS board mobilisation and remobilisation plans. At the start of the pandemic, health boards, in conjunction with their health and social care partnerships, were asked to submit to the Scottish Government Covid-19 mobilisation plans. We now have remobilisation plans as well.

On the basis of the mobilisation and remobilisation plans that were submitted by boards, what are the total estimated additional resources required by health boards and health and social care partnerships for quarter 1 of 2021 and for 2021 as a whole?

Joe FitzPatrick: Clearly, a lot is still to be worked through and a whole load of planning is on-going in relation to the second wave and other factors. Although it is difficult to answer about the longer term, I have a clearer picture in relation to quarter 1 of 2021. We anticipate a figure of just under £500 million for all health boards and integration authorities. However, it is difficult for us to estimate the longer-term picture at this stage.

Emma Harper: Are the Barnett consequentials sufficient to cover the additional expenditure that it is expected will be incurred? If not, how will any gap be funded?

Joe FitzPatrick: We are all trying to work within the envelopes that we have—that is the starting point. However, there remain significant uncertainties in the forecasts from NHS boards and IJBs, particularly in relation to spending on PPE, testing and remobilisation. There are also, of course, the implications of winter and a potential second wave—whether and how it will come. A lot of uncertainties remain. We are trying to mitigate all those pressures, in order to work within the funding envelope as it stands, which is at about £2.5 billion in consequentials.

Emma Harper: The Scottish Government has said that

"appropriate additional costs arising from COVID-19 will be met by the Scottish Government."

Can you help us to understand what "appropriate" expenditure is and how it will be met? What additional resources will be considered appropriate for health boards and integration authorities, and are they clear about what funding will be approved as additional Covid-19 funding?

Joe FitzPatrick: That is quite a big question. The short wraparound answer is that "appropriate" expenditure refers to a range of costs that relate directly to the needs of health boards or IJBs in responding to Covid-19. Examples of the areas covered include PPE, the employment of additional staff, beds and loss of income.

Emma Harper: Local authority and health board health and social care partnerships are all working flat out together, and there has been some really great practice in and inventive changing of their models of care and approaches. I am sure that prioritisation is on everybody's agenda. We might not talk about certain priorities right now, given that we are in the middle of a pandemic, but that is potentially something for consideration in the future. I am sure that the Government is working

with all the agencies to look at how we best manage the models for future spending.

Joe FitzPatrick: You are absolutely right. No one would have wished Covid on the planet, but it has shown the best in us all. In particular, there has been huge re-engagement in partnership working across all systems. That will help to inform some of the things that we might want to do in the future.

The Convener: What methodology has been used thus far to allocate the tranche of funding that has gone to health boards, and will the same methodology be used in future?

Joe FitzPatrick: Historically, funding was done through the NHS Scotland resource allocation committee, but we are moving to a hybrid approach, involving the NRAC formula and funding outwith that. While the NRAC formula is the basis, clearly there are times when it is appropriate to make spending allocations outwith the formula, because of different pressures.

The Convener: Is that the finalised methodology, or is there—[*Inaudible.*]

Joe FitzPatrick: That is likely to be where we are going. The uncertainty arises when there is a need to go outwith NRAC. That is based on evidence, on which we are working with boards and integration authorities.

David Stewart (Highlands and Islands) (Lab): I have a number of questions on social care. You may have touched on some of the answers in your opening statement. In fact, the convener stole my thunder with some of his previous questions. Nevertheless, I will move on to a couple of questions that I think are important.

Will you explain to the committee what scrutiny arrangements are in place for additional health and social care spending?

11:15

Joe FitzPatrick: Scrutiny is really important. We have to do it on a shared basis, both at the ministerial level and through the boards. The funding method for social care is similar to that for health boards, with a similar formula to that used by NRAC but slightly different with regard to the local authority aspect and some costs being based on actual cost.

Part of our work is to ensure that we understand that actual spend, and a huge amount of work is on-going with IJBs and providers to confirm their actual and forecast spend for social care. We do not yet have all that information, but we are considering that spend in partnership with boards and IJBs.

David Stewart: We obviously do not know the details yet of the statements from COBRA and the First Minister. We have all considered the R number and both the committee and the public are concerned about Covid-19. On the assumption that there is a deterioration in the R number and stricter conditions around how the public should behave, social care will clearly be an absolutely vital tool. You mentioned that further sums will go to social care. Are you able to utilise the contingency budget if we need extra emergency help for social care as a vital part of our Covid-19 planning?

Joe FitzPatrick: In short, yes. We need to understand what the needs are, so we are working with the Convention of Scottish Local Authorities and IJBs to understand the levels of funding that are required. Part of your question highlighted the uncertainty around what is happening and was based on an assumption about what might happen. I clearly cannot give numbers just now because we do not know what will happen, but we absolutely have to work with COSLA and IJBs to understand the required levels of funding that will be appropriate for an area that is a priority for us all.

Sandra White: I want to ask about the budget and PPE. I know that the Scottish Government has been successful in sourcing PPE both at home and abroad, and that it is working on manufacturing more PPE in Scotland, which is a really good thing. You mentioned the extra money for health that is coming in the autumn budget. How much has the Scottish Government spent to date from the current budget on PPE? In relation to Barnett consequentials, has that money been sufficient to cover expenditure on PPE?

Joe FitzPatrick: I want first to touch on the point that you made on sourcing PPE from Scottish manufacturers, because I think that there is a good news story here. Prior to the pandemic, I understand that close to 0 per cent—if not actually 0 per cent—of PPE was sourced from Scottish manufacturers. Around 49 per cent is now sourced in Scotland—more than 90 per cent is being sourced from Scottish manufacturers, if we exclude gloves. That is a really good news story that is probably worth highlighting.

To date, £170 million to £200 million has been spent on PPE, with approval for a further £113 million.

We do not have a crystal ball, but looking forward we need to make sure that we have appropriate stockpiles. You asked about Barnett consequentials. This is all really challenging in terms of costs and it is clear that we cannot spend money twice. However, there is no question but that the Government and all our partners understand the importance of our front-line NHS

and social care staff and other key workers having appropriate PPE. That is why it is good that we are now no longer reliant on the global market, which was a real challenge—[*Inaudible*.]—prices, and we are now able to source much of that in Scotland.

Sandra White: That touches on my next question. You mention that 49 per cent of PPE—up to about 90 per cent, excluding gloves, which you mentioned—is now sourced in Scotland. PPE was needed in social care settings and so on as well as in hospitals. Did the speed at which the virus spread and the need for PPE influence the options available for sourcing PPE? Was it difficult at first until we got the manufacturing in place?

Joe FitzPatrick: The challenge was that, with a global pandemic, everybody was trying to access PPE stock. That is why the Government stepped in when it became clear that the social care sector was not able to access PPE stock through its normal routes. There is no question but that we want to have a larger PPE stockpile going forward.

Sandra White: I will put my final questions together. You mentioned the stocking and sourcing of PPE for the social care sector, and you referred to work with COSLA and the IJBs in response to David Stewart. Is that how the sourcing of and payment for PPE is being managed? Have you worked closely with them, and has that been effective and efficient? What do you expect the on-going cost of maintaining adequate supplies of PPE will be?

Joe FitzPatrick: PPE for social care is being provided through the local delivery hubs, and that looks like it is going well. We need to consider what we will do in the longer term, because that was set up specifically for the current pandemic. There is a huge amount of on-going engagement with the social care sector, the PPE steering group, COSLA, the Coalition of Carers in Scotland and the whole load of partners that we are working with to make sure that we have appropriate stock and that that stock is accessible to the folk who need it.

Was your other question about cost?

Sandra White: Yes, it was about the on-going cost of maintaining adequate stocks of PPE. Do you have an idea of what that will be?

Joe FitzPatrick: It is probably too early for us to give the committee a meaningful figure, but the issue is under constant review with NHS National Services Scotland. It is key that we have appropriate stocks, particularly as we move into the winter period and beyond. Work is going on to understand that.

George Adam (Paisley) (SNP): The summer budget revision identified spending of £35 million for community hubs, which were established to provide a front-line community response for those affected by Covid. They were set up to take pressure off GPs and hospitals.

The committee is interested in those new and better ways of working, and we would like to find out more about them. Speaking to the committee on 11 August, Elinor Mitchell, the interim director of health and social care in the Scottish Government, said:

> "Community hubs are likely to feature in our future as part of our reshaping of access to unscheduled care."—[*Official Report*, *Health and Sport Committee*, 11 August 2020; c 23-4.]

You will understand that that seems quite exciting to the committee, from the point of view of considering different ways of working. Do you have any evidence on the effectiveness of the community hubs?

Joe FitzPatrick: I think that there is good evidence that the establishment of the hubs and the diversion of suspected Covid cases allowed our GPs to remain open and accessible at the forefront of activity, albeit often via digital technology. A significant number of consultations—more than 141,000—have been done through those hubs. If they had had to go through the GP system, that would have been challenging. As it was, our GP practices managed to continue, in a different way, with their out-of-hours services, the Near Me programme and telephone conversations. I am pretty certain that that would not have been possible without the hubs.

To answer your substantive question, boards have retained the hubs and will continue to do so for the foreseeable future. We will want to see whether there are lessons to be learned about how we provide primary care in the long term. We are already shifting from an assumption that primary care always involves someone going to a GP, and people are instead going to a range of providers, including pharmacies, opticians and so on. There will be lessons to be learned from the hubs about what more we can do in that regard.

George Adam: Did the fact that those 141,000 consultations went through the hubs have a massive impact on GPs' workloads? Do you have any evidence on that? If you do not have it just now, you could supply us with it.

Joe FitzPatrick: Currently, it would be difficult for us to get that data together, because we would have to get it from GPs. However, we know that GPs managed to continue to provide a service to their patients, and the fact that the huge workload associated with those 141,000 consultations was able to be diverted elsewhere must have protected their ability to do so.

George Adam: What would the implications be for future funding of primary care if we went down the route of this different way of working? You will be aware that, last year, the committee had an inquiry into primary care. A lot of the ideas that we came up with concerned ways of thinking cleverly about issues and about how we can deal with people who walk in off the street in a quicker and better way, and ensure that they are guided through the system.

Joe FitzPatrick: To an extent, that question involves my looking into a crystal ball to see what the future holds. What I can say is that, right now, we are talking about separate arrangements. Currently, the funding of the hubs does not impact on the funding of primary care—there are separate contracts. However, clearly, if we were doing this in the long term, we would need to think about that, in partnership with our primary care partners.

11:30

David Torrance (Kirkcaldy) (SNP): With the potential for a second wave, is the NHS Louisa Jordan hospital still able to fulfil its original role, if needed?

Joe FitzPatrick: Yes. The contract period was initially for five months, up to August. We have extended that, I think, to 13 months, to the end of April 2021. The hospital is ready to operate.

We have looked at how we can use the hospital for other purposes, to help us with other areas of the NHS. We are all working really hard to make sure that this does not happen, but if there were to be a significant second wave, it is important that we have that hospital.

The First Minister is making a statement this afternoon, and the COBRA meeting took place this morning. The work across the four nations of the UK is all about how we can protect the NHS from additional pressure. Therefore, it is important that we have that hospital available.

David Torrance: What are the on-going costs of running the NHS Louisa Jordan hospital? Is that a good example of pandemic planning by the Scottish Government? Over what timescale is the hospital expected to be kept operational?

Joe FitzPatrick: The timescale is 13 months, until the end of next April. I will check my papers for the figures on the running costs. Those are just under £2.4 million. That is in addition to the set-up costs, which were just under £31 million.

Those seem big numbers, but had we not managed to control the pandemic in the way that we did, and had the numbers of people in hospital risen in the way that we feared they might have, it was important to have that capacity available.

We must do everything to control the virus and protect the NHS, but it is important that we have extra capacity, should it be needed. We do not want to go back to the days of the First Minister having to read out triple figures for deaths.

The Convener: Will you clarify whether the £2.4 million figure is the monthly running cost of the hospital?

Joe FitzPatrick: Sorry—yes, that is the monthly running cost.

Donald Cameron (Highlands and Islands) (Con): My questions are about the second wave, which is much in the news. What funding has been made available to support the preparations for a potential second wave in the weeks and months ahead?

Joe FitzPatrick: There is a huge amount of work going on. I do not think that I can give you specific numbers. Perhaps Richard McCallum can help out.

Richard McCallum (Scottish Government): There are three aspects to that. First, there has been no confirmed additional funding for a second wave from a UK Government level in terms of consequentials, albeit that we have had indications of our overall funding envelope for the remainder of the year. Therefore, there will be an on-going discussion about funding with the UK Government.

Secondly, as Mr FitzPatrick indicated, we have had confirmation of consequentials of £2.5 billion. We will be making best use of those consequentials in planning for a second wave.

Thirdly, again, as Mr FitzPatrick has commented on, we need to ensure that we get the money out to health boards and partners, including integration joint boards, as early as possible, so that they can make the necessary plans for winter and beyond.

Donald Cameron: I am sorry to say this, but I do not find that answer entirely satisfactory, because this is not just a question of consequentials. Surely the Scottish Government has made plans for a second wave, and part of that planning must involve a financial assessment of what is needed.

Therefore, I ask again for specific numbers on what Government funds have been at least assessed as necessary to support a second wave. If truth be told, we have all accepted for some time that that is a distinct possibility.

Joe FitzPatrick: Work is on-going to consider what would be required in a range of scenarios. We are working with NHS boards, local authorities and right across the sector to ensure that we have as many plans in place as possible. Part of that is

our winter planning programme, which has been established to co-ordinate across the health boards and social care partners. One example of the work that we are undertaking is the largest flu vaccination programme that Scotland has ever seen. We are working on that alongside our partners in the UK, who are starting on the largest programme that the UK has ever seen. That is all about how we keep the pressure down.

It is absolutely right that we continue to plan and work as best we can to utilise the funds that we have. There is a responsibility on us all to do what we can to protect the NHS and to try to avoid the second-wave pressure landing on NHS boards in a way that is really challenging. Work is on-going with NHS boards and right across the system to understand what might be required in a range of scenarios. Right now, we need to do that within the funding envelope that we have in Scotland. Clearly, if additional funding comes through further consequentials, we will be able to look at how we use that, too.

Donald Cameron: I do not deny anything that the minister has said, and I accept that he is standing in for the cabinet secretary, but I find it extraordinary that he cannot give a figure or at least an estimate of what the Scottish Government's expenditure might be in preparing for a second wave.

Joe FitzPatrick: At the end of the day, I do not have a crystal ball, and nor does the Scottish Government. Everything that we are doing is about trying to use our magic wand as best we can. That is about the public and all our services working to minimise any danger of a second wave and trying to ensure that it does not happen. That is why a COBRA meeting is happening just now. As I understand it, no politician anywhere across these islands, including Matt Hancock, could give you the number that you are asking for, because none of us has a crystal ball.

I am sorry that I cannot give you the answer that you are hoping for, but that is probably because the answer does not exist. However, I can assure the committee that work is going on to look at a range of scenarios and to plan for them as best we can.

Donald Cameron: I will move on from funding. Obviously, various indicators could be used to represent a second wave. It might be infection rates, the reproduction number, admission rates to hospital or admission rates to intensive care units. In your view, what represents a second wave? At what point would an increase in the various indicators mean that we might see a cessation of elective treatments, for example, because we are returning to lockdown or semi-lockdown?

Joe FitzPatrick: I am not sure whether members watch the First Minister's daily briefings but, either at the end of last week or early this week—I think that it was last week—Jason Leitch was asked roughly that question, and he answered by suggesting that, in an ideal world, we would have in effect a dashboard of all the indicators that Donald Cameron mentioned. If all the indicators are low, we can say easily that everything is green and, if they are all high, it is easy to say that things are challenging and we are moving into a second wave.

Clearly the real world does not work like that, and it is likely to be a journey based on a range of those factors. Those judgments are made by the First Minister and advisers on a daily basis after they look at all the figures to understand where we are going. I am pleased that today that is happening to some extent on a four-nations basis. COBRA can ensure that ministers across the UK are able to look at that evidence together to see whether a common approach is possible.

Sandra White: Minister, I want to carry on with the question about funding and a second wave. Does the Scottish Government have figures on how much has been spent on testing to date?

Joe FitzPatrick: I do not think that we have an exact figure just on testing, but I think that we are operating within an envelope of the consequentials of £136 million—I think it is within that figure.

Sandra White: Thank you. I asked that question because, with regards to a second wave, you have already mentioned that nobody has a crystal ball, so we do not know how much funding is expected. I am sure that the committee may write to you or the cabinet secretary for an update on that matter.

There has been talk about testing and, in particular, what measures are being taken to address what has been described as people not being able to get tested—although I note that the Lighthouse lab in Glasgow, where well over 40,000 tests have been done, is the most successful testing lab in the UK. If anyone has looked at the graph that was in, I think, *The Times*, they will see that Scotland is at the top for testing.

How would you address the questions that have come forward about pressure being put on testing labs? I recognise that we are hoping to work with UK labs and our NHS labs. The figures that I just mentioned appear to me to say that Scotland is pretty much at the top of the testing, although some areas might be lagging behind. Do you know what measures are being taken to address the pressures? There have been comments that there are not enough people in the labs. Do you have any information in relation to those comments?

Joe FitzPatrick: There is not a league table as such, but across the four nations we are all trying

our best to make sure that the testing that is needed is available. That is our approach to working with the UK Government with regard to the Lighthouse lab.

There is huge pressure on the UK-wide testing programme. There is immense strain as demand continues to outstrip capacity, so we are continuing to work with the UK Government to build pathways and laboratory processing capacity. We have sought assurances to ensure that Scotland receives that Scottish share of capacity, but part of the issue is that some of the growth in capacity that the UK Government had planned is not going as quickly as it had hoped.

We are all working together to improve capacity and, as you have mentioned, one way that we are trying to help is by looking at whether we can bolster the NHS capacity to take on some of the workload. Clearly, however, we need to make sure that we still have access to our population's share of the UK labs and are not just robbing Peter to pay Paul; we need to make sure that there is an overall advantage to us in that work.

There is a range of issues, and we are working very hard to make sure that capacity in Scotland meets the demand. It is very important that people have access to tests if they have Covid symptoms.

11:45

Sandra White: Glasgow Caledonian University has recently opened its ARC health and fitness centre as a Covid testing centre. People in my area can phone up and make an appointment to be tested there. That system has been operating successfully, and quite a few people have been going along there during freshers week. Is that the type of progress that the Scottish Government hopes to make, along with the UK Government? Will there be more localised centres that people can just walk to for testing rather than having to take a taxi or bus there?

Joe FitzPatrick: Yes. Forgive me for hesitating while I obtain the exact number, but I think that that now means that there are two such centres out of the 20 or so that we expect there to be across Scotland. Ensuring that people can access testing when they have Covid symptoms is very much part of our approach to increasing testing capacity. However, it is important that people should go for testing only when they have those symptoms: some of the pressures that have resulted elsewhere appear to have been caused by people going for tests when they do not have such symptoms.

Brian Whittle: Good morning, minister and Mr McCallum. My question is on pandemic preparedness. I think that we would all recognise that we were not set up for the type of global pandemic that has hit us. That is despite there having been initiatives such as the Silver Swan exercise, many of the recommendations from which were not followed.

The level 4 budget information for 2020-21 shows that £14.9 million is set aside for board resilience, to maintain the preparedness of the Scottish Government and the NHS for an influenza pandemic. Looking ahead, I presume that we expect a high level of spending on pandemic preparedness to be required in future years.

Joe FitzPatrick: In light of the coronavirus pandemic, the answer to your question is almost certainly yes. The cost of maintaining a national stockpile of medical and other supplies and equipment to deal with any future pandemic—not just an influenza one—will be higher than it was in previous years.

As I said in reply to an earlier question from Sandra White, at the start of the current pandemic one of the challenges was that everyone was trying to access PPE supplies at the same time. Although we did have stockpiles, the only new orders that we could secure were with international suppliers. However, we now have significant capacity to manufacture PPE in Scotland. Part of our long-term planning will involve looking at how we might sustain that here, to ensure that we would not have to compete with the whole world if we had to buy PPE in the context of a future pandemic.

Brian Whittle: You have highlighted the issue of PPE supplies. Quite rightly, we have addressed that by ensuring that we now have local access to such supplies and so would not be caught out again in the way that, globally, everyone was recently in a scramble for the same products. However, our approach must cover not just that issue but how we structure our NHS to ensure that it would be prepared for any future pandemic. What additional funding is expected to be required for that in future years? How is the NHS being structured to cope with any future pandemic issues?

Joe FitzPatrick: The first point to make is that we are still in the midst of this pandemic—and events over the weekend have shown just how real it is.

In the long term, we are committed to ensuring that health and social care services in Scotland have access to the type and level of medical equipment and supplies that would be required to combat any future pandemic. However, there is no question but that a huge amount of learning will come from the current one.

In the past, we had always assumed that any pandemic would be like the flu, but it is clear that there are significant differences between what is

required for a response to Covid-19 and what is required for a response to a global influenza pandemic. That is part of the learning that we will all take.

The priority now is dealing with the current pandemic, but you are absolutely right that we need to ensure that our health and social care service has the correct resources and that we learn any lessons that we can from the pandemic to help to influence our response to future pandemics. It is clear that the lessons from the pandemic will not just be about planning for future pandemics. We have learned to do a number of things differently and at a different pace than we probably thought was possible.

George Adam: I want to ask about service innovation, which is connected to my earlier questions. In going through the budget process, the committee has heard from health boards and IJBs that have said that the worldwide pandemic has made them look at different ways of working. One went so far as to say that the pandemic was the main reason for that. The Scottish Government has been pushing that agenda for some time. Why has it taken a worldwide pandemic for many partner organisations to finally look outwith their silos and deliver services differently?

We have taken evidence, which you will probably be aware of, from Vicky Irons, who is chief officer of Dundee health and social care partnership. She said:

"The first principle of Dundee IJB's remobilisation plan is that people will attend buildings for assessment, treatment and care only where no alternative is available. That is because we are still in a period of risk around people being in enclosed spaces, but it is really an indication of what we should be striving for in terms of our provision of care in the future."—[*Official Report, Health and Sport Committee*, 8 September 2020; c 22.]

I go back to what I asked earlier. Surely the new ways of working from this difficult time should be continued by health boards and IJBs. Nine times out of 10, it has been the IJBs that have been put to the side and the health boards have carried on. Surely there are better ways of working. The approach has to be patient centred; it must be the patient who is important, not the structure.

Joe FitzPatrick: Prior to the pandemic, there was almost certainly resistance to moving to some of the new ways of working, such as Near Me, not just by patients but by service providers. However, we have seen that resistance go away because of the pandemic. All of a sudden, folk have realised the real potential of some of the new ways of working.

Near Me is probably the biggest example and the easiest one for me to talk about. We had planned the changes for Near Me, although we expected to take around two years to deliver it. Because of the pandemic, we managed to deliver it in six weeks. Prior to the pandemic, patients, GPs and others would have said things such as "That won't work. I need to see all my patients face to face" or "No, I need to see the doctor directly." I do not think that people will want to go back from having the huge range of benefits from GPs being able to see them more efficiently or from being able to take 15 minutes for a 15-minute appointment rather than taking time to travel to a GP surgery, sit in the waiting room and then go back to work.

There are a huge number of benefits from new ways of working, and I do not think that we will go back to the old ways. I think that people will realise that we need to try some new things. We might not think that some things are a good idea, but sometimes we just need to try things, and we might be pleasantly surprised—as we have been with Near Me, for instance.

George Adam: You make a valid point, minister. Patients do not really care how they navigate the health service, as long as they find a way through and are dealt with.

Will there be less reliance on hospital care in the future? Can positive lessons be learned about how to retain the innovative ways of working that have been adopted during the pandemic?

Joe FitzPatrick: The importance of shifting the balance of care is clear; we have been trying to do that for a considerable time. In summary, then, the answer is yes.

George Adam: A lot of people have been working from home during the pandemic. Not every employee of a health board or integration joint board is on the front line, serving patients. Is there scope for more home working in health boards and IJBs? Would that have a knock-on effect on budgets and the idea of centralised office-based functions? We might not need offices in certain NHS sites in Scotland if we embraced home working.

Joe FitzPatrick: Not just boards but all employers should be considering that. Home working is really important now, during the pandemic, to help to stop transmission of the virus, but it also brings huge benefits in the context of the climate change agenda. It is becoming easier to do, and I think that boards should be considering it—Office 365 and other IT products are used in NHS boards.

The approach needs to be wider. IJBs, which you mentioned, could consider it—although sometimes people need to be at work. Today, roughly half the committee is in the Parliament; the other half is working from home, which shows that we are all able to work differently—and we are becoming more adept at doing so.

You mentioned savings. A fair bit of work is going on to evaluate the costs. However, it is not necessarily about savings; it is about spending the right money in the right place, to make the differences in health that individuals want to see.

George Adam: It is also about improving the quality of life of staff. Working from home can give people a better balance between their work and personal lives.

Joe FitzPatrick: Indeed.

The Convener: We must move on. David Torrance will ask about the financial stability of health boards.

David Torrance: Minister, do you anticipate a need to provide on-going financial support to the four boards that received additional funding in 2019-20, aside from Covid-related support?

Joe FitzPatrick: It is too early to say. We will review the position over the remainder of this year.

David Torrance: Will the in-year support require to be repaid? If so, over what timescale?

Joe FitzPatrick: That takes me back to a question that Emma Harper asked. Clear, Covid-related additional costs will not require to be repaid by health boards or integration authorities.

David Torrance: Does the Scottish Government anticipate that the boards that require in-year financial support will be able to achieve a break-even position within three years?

Joe FitzPatrick: That should be the target of the boards to which it relates, but we will need to understand the impact of Covid.

12:00

David Torrance: How will the coronavirus pandemic impact on the ability of boards to break even over three years, as required?

Joe FitzPatrick: I will sound like a broken record here, but it is too early to give a clear position. We do not know the long-term cost implications of Covid at this stage, so that would be challenging. I apologise for not being able to be clearer on that.

The Convener: I have a question for Richard McCallum. The cabinet secretary previously indicated that the development of the three-year financial and savings plans was paused at the outset of the pandemic. Has the planning been resumed yet, and what assessment can be provided of the impact of Covid-19 on finances?

Richard McCallum: The financial planning has been very much focused on the in-year position and making sure that we understand the full costs of this year. I know that the committee has heard about that from the boards in Ayrshire and Arran, Glasgow and Lothian. We are having discussions with the health boards about their immediate financial plans.

In view of the upcoming budget in December, we will be looking at the longer-term financial plans. As the minister said, there is a lot of uncertainty about the future and the likely costs, but we are starting to build up that picture with health boards, which will give us indications of what will be required over the next three years. It is still our intention to have longer-term three-year to five-year financial plans in place.

Donald Cameron: On a similar theme of longer-term financial planning and structures, in October 2018 the Scottish Government set out its medium-term financial framework for health and social care. At that stage, it identified the need for savings of about £1.7 billion over the period from 2016-17 to 2023-24. Obviously, a lot has changed since then, but can you tell us when the Scottish Government might be in a position to update the medium-term framework to reflect the impact of the pandemic?

Joe FitzPatrick: We are still in the pandemic, so it is difficult to understand when we will get the lessons from it to feed into that framework. We can write to the committee when we have that information.

Donald Cameron: Does the experience of the pandemic suggest that we will see a shift towards more centralised control of resources for health and social care?

Joe FitzPatrick: Yes and no. In the short term, for the immediate pandemic response, that is the case. However, as the system responds to the impacts of Covid, local recovery and redesign will be key.

The Convener: Thank you. We move on to questions about integration, which is an on-going issue for the committee.

George Adam: The minister said that he feels as though he is repeating himself a lot. I feel that I keep repeating myself because all my key questions have been about how we can work better and whether an integrated model might be the way forward. This section is on the integration model during the pandemic, which has offered both opportunities and challenges for the operation of integration.

As the convener said, integration is an issue of interest to the committee, which has highlighted the slow progress that has been made towards achieving it and the persistence of a silo mentality in a lot of the organisations and partners involved. Health money and social care money continue to be treated as two distinct pots of money, rather

than losing that identity, as intended, and becoming part of how to solve the problem. Individual organisations still see it as their money.

The Scottish Government's lessons learned report has highlighted both positives and negatives for integration through the pandemic. Does the minister feel that the system has responded well, or have the known challenges been exposed?

Joe FitzPatrick: Gosh! That is quite a wide question. Rather than giving you my thoughts, I will give you the thoughts of some of the partnerships. We are hearing from them that what we achieved during the pandemic would have been much more difficult without integration. The closer partnership arrangements that have built up in recent years under integration between managers, professionals and health and social care workers have been particularly valuable in helping us to respond more rapidly and to be more agile. The joint working practices that were developed previously helped, and because of the pandemic we have accelerated that process of integration, folk working together, and looking at the bigger picture rather than staying in silos.

George Adam: There are all these experiences and examples of how things have worked at the coalface when things have been really difficult. Nothing brings out the best in people like a challenge of this magnitude. I have been listening to organisations in my area, which is covered by NHS Greater Glasgow and Clyde, that say that they have brought in all these new structures and ways of doing things, but it still sounds as though they are talking about working from the centre. Is it not the case that, with these new structures and ways of working, the patient should be the most important person and decisions should be made about the patient's way through the health service and social care, as opposed to relying on control from the centre? My big fear is that, when and if we get through this, we will just revert to normal. We have experience of some health boards in the past just going back to their old ways of thinking and working.

Joe FitzPatrick: Most of your question was just a matter of fact, and I concur with the points that you made.

On the suggestion that we might just revert to normal—whatever normal is—it is really important to make sure that we are learning from best practice. That work is being done and there are some really good examples of best practice and how integration is working coming from various parts of Scotland. I have examples of that in front of me, but I know that the committee's time is tight. My main point is that it is important that we make sure that we do not lose that, and when things are particularly good, we do not keep it for one area; we make sure that it is shared across the system and that it works for Scotland.

George Adam: If you could send us the examples of where that approach has worked, and how well it has worked, it would be interesting for the committee to see them as part of its on-going work.

Do you believe that partners have been represented equally in decision making through the pandemic? That has not been the case in the past with some partners, particularly with integration joint boards and various social care elements being put to the side.

Joe FitzPatrick: I guess that I am talking just from my experience. People have learned very quickly that we are all in this together, to use a little bit of a cliché. Looking at the bigger picture, which is, as you say, about putting the patient at the centre of decision making, good progress has been made across a range of areas towards that patient-centred approach.

Brian Whittle: A repeated theme of the committee's inquiry has been the lack of progress towards the financial empowerment of IJBs. The ministerial strategic group highlighted that, as George Adam said, there should be a focus on outcomes rather than on the public body that put the pound in the pot. Our inquiry has found that that is not necessarily the case. The guidance suggests that

"a key aspect of governance and accountability between partners ... has previously been largely unrecognised, with the effect that there is a lack of transparency, governance and accountability for integrated functions that are under the control of IJBs".

Minister, do you recognise that there is an on-going issue in relation to the financial empowerment of IJBs? Do individual partners continue to influence the allocation of resources?

Joe FitzPatrick: That has not been my experience. Through the pandemic, there has been close working across the system in a way that, before the pandemic, we all would have said that we wanted. The pandemic has shown the best of the partnership working across the system.

Brian Whittle: With the greatest respect, minister, I ask you to read some of the evidence to the committee's inquiry that suggests otherwise. However, I agree about the pandemic; as per some of George Adam's questions, it seems that it has taken a global pandemic to force partners into collaborative working.

How are directions being used by IJBs to ensure that resources are used in line with the Government's strategic commissioning plan? How are you measuring that?

Joe FitzPatrick: Directions are an interesting aspect. They should be used when required, but there is strong evidence to suggest that good partnership working, rather than directions, is key. Directions should be used where appropriate as part of the process, but if partners are learning anything through Covid, it is that building strong relationships and partnerships is what is helping us deliver for the person who is at the centre of whichever service we are providing. There are good examples of that.

Brian Whittle: As you say, there is good practice among certain IJBs. How is the Government ensuring that good practice is shared around the whole country? How might IJBs make better use of good practice and directions to improve transparency, governance and accountability, which the committee's inquiry has highlighted as being important?

Joe FitzPatrick: One of the important bodies that has been set up recently is the ministerial recovery group, which pulls together a range of partners from not just across Government but IJBs and health boards—there are also trade union representatives and others—to ensure that we hear all experiences as we develop our recovery plan. We are doing that with as much evidence as possible.

12:15

Emma Harper: I have a couple of questions. One is about the set-aside budget and the other is about a longer-term shift of the balance of care. In response to George Adam's question, the minister talked about service innovation and new ways of working; shifting the balance of care is part of that. As a result of the pandemic, does the minister expect there to be a longer-term shift in the balance of care between hospital and community care? The pandemic has caused a rapid shift in some of those innovative services, leading to the transfer of care.

Joe FitzPatrick: Yes, we have been making good progress—[*Inaudible*.] The target is to deliver more than half of our spending on community health services by 2021-22. The baseline was 47.7 per cent at the beginning of the parliamentary session; that increased to 49.7 per cent in 2018-19. The committee will be aware that the budget for this year sets out a further shift in the balance of care. We are making good progress and we will see the figures coming in. I am confident that the work that we have done this year will show the balance continuing to shift.

With regard to the impact of set-aside budgets, during the Covid crisis our primary focus has been to make sure that the person who needs the care gets the right care in the right place at the right time—a point that was made by Brian Whittle and George Adam.

Emma Harper: The committee has heard evidence that the set-aside budget is often treated as being under the control of the NHS board, rather than the IJB, with the result that it is difficult for IJBs to use the money to implement preventative services. In our social prescribing inquiry, we heard a lot about preventative services and how important it is to keep folk out of hospital. Does the minister agree with the findings of the ministerial strategic group for health and community care that set-aside budget arrangements might still not be working effectively? Does he think that there are ways that we can improve how that budget is working or assigned? I know that some health boards, such as NHS Dumfries and Galloway, do not call it set aside but, to me, those findings mean that it needs to be looked at.

Joe FitzPatrick: You are right that we do not yet have full clarity on the extent to which Covid spend across the sector would have impacted on that spend. Yes, we need to keep a close eye on that and make sure that there is transparency around that going forward.

David Stewart: I have a few questions on delayed discharge. In the report on "Lessons Learned from Reducing Delayed Discharges and Hospital Admissions", delayed discharge was ascribed to "deep rooted behavioural issues" and "a lack of trust". What assessment has the minister made of the report and the above no-holds-barred comments?

Joe FitzPatrick: It is important that we continue to work with health and social care partners during the pandemic and that we continue to look at reports such as that one to help guide us going forward.

David Stewart: I will follow that up. Clearly, there have been major problems in the structure of Scottish health services with regard to delayed discharge. Perhaps you could say that it is too early to have learned any of the lessons; you replied to George Adam about that. Have any lessons been learned about how we manage delayed discharge in the post-Covid-19 future?

Joe FitzPatrick: Clearly, we will need to continue to learn lessons, but there are certainly some really good examples of good practice that we can point to. We have to remember that the patients who we are talking about are people who no longer require to be in hospital. It is a primary objective that they should not be there.

There are particularly good examples. Given the convener's local interest, I flag up an example in Aberdeen City Council, where spare housing capacity was utilised to provide extra housing for

care flats with a voluntary provider. Unused space in buildings was quickly adapted to provide an additional 10 flats, and 13 supported hospital discharge rooms were provided in sheltered housing. That could have been done before the pandemic, but it was not. That is an example of people working across the system to find a solution that works, not just for Aberdeen City Council or NHS Grampian but for the individuals involved.

We need to look at all the examples and do our best to ensure that best practice is the norm, rather than something that we just roll out during a pandemic.

David Stewart: Committee members and the minister are well aware of the damaging effects that delayed discharge can have on vulnerable people, particularly elderly people, who should not be in hospital. The committee has taken evidence on that. As has been said in a slightly tongue-in-cheek way and in inverted commas, hospital is not a good place to be if you are unwell—we know about the massive loss of muscle tone as a result of delayed discharge, which affects health and makes life more difficult. Can the reduced levels of delayed discharge that we had in March and April be sustained, and can delayed discharge even be eliminated altogether?

Joe FitzPatrick: The bottom line is that we need to ensure that that is the case, for all the reasons that you set out. All Governments have tried hard over the years to reduce levels of delayed discharge for the reasons that Mr Stewart mentions. We have now got to an improved position, so the whole system needs to work really hard to sustain that.

The Convener: There is clearly much meat in what we have covered, and many issues to which we will return. You have made a commitment to come back to us with more information on a number of areas. We will watch carefully for the autumn budget revision in the next couple of days. In the meantime, thank you very much for attending and for dealing with such a wide range of questions. I also thank Richard McCallum.

We now move into private session.

12:23

Meeting continued in private until 12:46.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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