OFFICIAL REPORT
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Health and Sport Committee

Tuesday 1 September 2020

Session 5

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HEALTH AND SPORT COMMITTEE
21st 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:

Hazel Borland (NHS Ayrshire and Arran)
Derek Lindsay (NHS Ayrshire and Arran)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 1 September 2020

[The Convener opened the meeting at 10:00]

Pre-Budget Scrutiny 2021-22

The Convener (Lewis Macdonald): Good morning and welcome to the 21st meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton.

The first item on our agenda is an evidence session on the Scottish Government's budget for 2021-22. The committee's approach to scrutiny of the budget reflects the approach that was recommended by the budget process review group, which entails addressing budget implications throughout the year and bringing that information together to inform a pre-budget report for consideration by the Cabinet Secretary for Health and Sport. This year, the committee has agreed to undertake pre-budget scrutiny of the budget while bearing in mind the impact on health and social care of Covid-19. The committee intends to take evidence from a number of bodies this month, and we will hear from the Cabinet Secretary for Health and Sport at the end of the process.

Today, in the third in this series of meetings, we will hear from representatives of NHS Ayrshire and Arran. I welcome Hazel Borland, who is interim deputy chief executive and nurse director, and Derek Lindsay, who is the director of finance. Members will ask questions in a pre-arranged order, as we usually do when we hold online meetings.

The board has identified a number of direct and indirect impacts of Covid-19 on the delivery of health services in the Ayrshire and Arran area. What assessment has been made of the potential indirect health impact of Covid-19 as a result of the drop in performance in areas such as in-patient and out-patient care, imaging and endoscopy?

Hazel Borland (NHS Ayrshire and Arran): Our assessment has shaped our remobilisation plan. As you can imagine, our focus has been on enabling that process to be clinically led and clinically prioritised, and on ensuring that we are making that assessment in line with robust infection prevention and control, and that those services and the assessments that we make can focus on the safety of our patients, staff and communities.

At the moment, there has been an impact across our health and care system. We have been focusing on the services that we have been able to provide and on how we can restart services. There has been an impact on our workforce, and we are making an assessment of the workforce needs that we will have in the future. We have also been focused on our test and protect system, to ensure that it can meet the demands on it. Wrapped around that, we are making a financial assessment to ensure that, whatever needs assessment and clinical prioritisation we make to enable our services to restart, we are clear about the financial impact of that, in terms of what it has been for the first five months of this year, what it will be until the end of March 2021 and what we think that it will be in 2021-22.

I am happy to answer any detailed questions about specific health and care services. Derek Lindsay, as director of finance, might be able to provide more detail on the financial assessments.

The Convener: Thank you very much. Before we move on to finance, I would like to ask in general terms whether, in the context of the lockdown and all the difficulties that it has brought, you have been able to strike the right balance between the direct health impacts of the Covid crisis and the indirect health impacts, such as delays in services and so on.

Hazel Borland: We have tried hard to make sure that we have focused on understanding the impact of being unable to deliver a range of our services and to manage, through a variety of community focused means, to enable our communities and our population to stay as well as they possibly can. There were 16,000 people across our communities who were shielding, so we tried hard to focus on the needs of that specific vulnerable community across Ayrshire and Arran, to make sure that they were supported in the best way possible.

Our prime focus has been on maintaining safety and maintaining contact across a range of vulnerable communities to make sure that we are sighted on their needs and that the impact on those vulnerable communities is as minimal as possible, while recognising that there will inevitably be an impact. We are trying to make sure that we plan for that as much as we possibly can.

The Convener: In addressing the question that we asked you about what steps you are taking to work with services that have been impacted by Covid, you said that you would be validating waiting lists. Can you explain what you mean by the validation of waiting lists?

Hazel Borland: That validation has enabled our clinicians for each of the specialties to drive that

process and to review the waiting lists to prioritise the patients and members of the community who are on those waiting lists according to their clinical need.

As of the end of last week, we had restarted approximately 87 services, and that validation has enabled our clinical teams to make sure that the patients with the highest clinical need are being seen first. That is not necessarily about where they are on the waiting list. We have enabled those clinical teams to clinically prioritise and make sure that the patients with the greatest clinical need are being seen in a timely manner. That means that the patients who most need to be seen are being seen first.

The Convener: I imagine that that is quite a complex and difficult process. Essentially, it means that people who were on the waiting list are still on the waiting list but they might be further back and further away from treatment than they would have anticipated under ordinary circumstances.

Does that process involve a lot of clinical effort to identify those priorities in the way that you describe?

Hazel Borland: Absolutely. It has required a great deal of effort, time and resource from our clinical teams, but they have absolutely wanted to do that to make sure that they have clinical control and because their provision of clinical leadership of that process is the right thing to do.

For example, our surgical restart group is being led by one of our consultant surgeons. That group is clinically led to make sure that the services that have restarted have had that clinical prioritisation in mind and that all those different needs have been thought through in the clinical pathway from end to end.

The Convener: If you are not seeing patients because of the restrictions that they are under and the restrictions on your services, I suppose that the difficulty is how to get up-to-date clinical knowledge to make those prioritisation choices in a different way from before.

Hazel Borland: That has involved conversations with other colleagues—for example, the consultant for a particular specialty might feel the need to contact the patient's general practitioner again to look at their most up-to-date blood results. It is a case of understanding what some of those investigations might mean and identifying whether further diagnostics are required, while recognising the limitations that there have been on those over the past five months.

In addition, clinicians have been able to undertake a range of interventions with patients. We have been holding telephone consultations; we have been using the NHS Near Me service; and we have been doing face-to-face consultations when the clinical need has demanded it. A significant number of face-to-face consultations stopped, which was right and proper, but the consultant and the wider clinical team have felt it necessary from a clinical perspective to see a small number of patients in order to make a proper assessment, and those assessments have taken place.

The Convener: As regards the overall impact that you have described—creating extra capacity or accessing capacity outside the board's area at the Golden Jubilee national hospital, for example—have you made an estimate of what it will cost the board to get its performance measures back on track?

Hazel Borland: I need to pass the question about a financial estimate for getting back on track to Derek Lindsay, as director of finance—he might be able to provide some level of detail—but we are absolutely in direct communication and collaboration with the Golden Jubilee and NHS Louisa Jordan, so we can plan for that. I will be more than happy, at some point during the meeting, to share some detail on what we anticipate that we will use those facilities for.

The Convener: I expect that we will return to Derek Lindsay once he has rejoined us. In the meantime, I will pass over to my colleague David Stewart.

David Stewart (Highlands and Islands) (Lab): Good morning. I will continue on the theme of waiting lists. [*Inaudible*.]—asked about your estimation—[*Inaudible*.]—will return to pre-Covid-19 levels of performance?

Hazel Borland: I am sorry—I lost part of that question, but I think that it was about when we think that we will get back up to our pre-Covid level of performance.

David Stewart: Yes.

Hazel Borland: From an in-patient and day-case perspective, I have been advised that, as at the end of July, we were operating at 46 per cent of our performance. Due to the need to maintain safety, the requirement for personal protective equipment and social and physical distancing, and the impact across a range of our environments and facilities—including the need to stagger appointments, the effect on theatre capacity and the number of patients on lists, at this point—

Derek Lindsay (NHS Ayrshire and Arran): I can hear Hazel speaking now.

The Convener: Please carry on, Hazel. Derek Lindsay has just rejoined us.

Hazel Borland: At this point, we are uncertain as to exactly when we will be able to get back to pre-Covid levels. We are currently at less than 50 per cent, in common with a number of other boards across Scotland. With the current restrictions, we do not anticipate that changing significantly beyond 60 per cent by the end of the calendar year, and potentially to the end of March 2021, because of the need to maintain safety measures to prevent the transmission of infection.

David Stewart: Thank you—that was a very helpful answer.

What impact would a second wave over the winter have on performance in terms of timescales, health outcomes and finance?

Hazel Borland: I anticipate that if we experienced a significant second wave, we would go into a similar cessation of activity, in taking a safety perspective. We would have to put in place exactly the same mechanisms that we had in place at the beginning of the pandemic. We would need to increase our intensive care capacity, we would need to cease elective activity and, from the perspective of primary and community care, we would need to move back to a digital approach to seeing our patients.

The only impact that a significant second wave would have on waiting times would be to increase them. The worry would be about the impact on health outcomes across our population and among patients with needs that were waiting to be met. We would need to assess those at the time that that happened. There is no doubt that, if we had a second wave, we would need again to carefully consider cessation of elective activity in order to meet the anticipated Covid-related need.

10:15

The Convener: Thank you. I think that Derek Lindsay is online again, so I will put this question to him. In relation to the extra capacity that has been created in Ayrshire and Arran following the lockdown and attempts to restart services, has an estimate been made of the potential costs of creating extra capacity so that you can get performance measures back on track?

Derek Lindsay: We are required to have double our ITU capacity immediately available within a week and to have the ability to increase to three times our normal capacity within two weeks. That incurs additional costs. We have created Covid beds for patients who come into hospital with Covid, and carrying forward testing comes at significant additional cost. Therefore, at the end of July we submitted to the Scottish Government a remobilisation plan, which set out all the additional costs that had been identified.

We require public health capacity to deal with outbreaks, and our colleagues from local government and the health and social care partnerships have identified costs in relation to the provision of protective equipment to their staff and sustainability payments to councils for care home providers.

In total, the requirement that has been identified to cover all those costs is about £67 million for the remainder of this year—that is, from 1 April to the end of this year.

The Convener: Does that include integration joint board additional costs?

Derek Lindsay: Yes, that is correct: that includes IJB costs.

The Convener: Thank you.

Brian Whittle (South Scotland) (Con): Good morning to the witnesses. As was the case for many NHS boards, the delayed discharge numbers in Ayrshire and Arran fell sharply during the pandemic. The figure went down from 129 in March to 52 in April. The Government made funding available to allow that to happen. How was the additional funding used to reduce delayed discharges?

Hazel Borland: We took the opportunity to use the funding across a range of settings. Some of it enabled us to fund additional beds in community settings and some of it enabled us to fund additional care at home. We were able to fund additional health and care staff so that more people could be cared for in their own homes. We commissioned care beds in care homes and we were able to plan to open beds, if required, in our community hospital settings. We really tried to think across a portfolio of opportunities so that we could maximise the approach as the need arose.

Brian Whittle: It is interesting that, during the pandemic, you have been forced to make significant changes in how you approach delayed discharge. Have you had an opportunity to carry out a cost benefit analysis and consider the cost of looking after those patients in care homes or at home versus the cost of looking after them in hospital? Will the additional funding have an impact on your finances in the future?

Hazel Borland: We have not yet had the opportunity to do a cost benefit analysis, but I have no doubt that we will look at the issue in the context of our ambition to deliver as much care as possible close to home and in our communities. Given time, I am sure that we will do that work to ensure that we understand exactly what the impact of the approach has been.

Derek Lindsay: [*Inaudible*.] We have been working with our integration joint boards to consider the best balance of care. As well as it

being clinically better for patients not to remain in hospital for longer than they have to, because their independence deteriorates and so on, the cost of somebody being in a care home is about a quarter of the cost of keeping them in hospital, and if they can be supported in their own home, that costs even less. There is a financial benefit to minimising the number of people who are in hospital.

One of the objectives of the integration joint boards is to commission and support the right balance of care. There are costs and benefits in shifting the balance of care, which has been Scottish Government policy for some time.

Brian Whittle: To maintain the reduction in delayed discharge, will an increased level of funding have to be maintained?

Derek Lindsay: It is about working with our integration joint boards to maintain the current improved position. They will require sufficient funding to be able to maintain the current capacity, but the demographic of an increasing elderly population means that there is also a need for that to continue to increase.

Clearly, the Scottish Government needs to consider the right balance for health board and IJB funding, but we are working very well with our local integration joint boards to see that change happens and to establish the right balance of care.

The Convener: You mentioned additional costs, but will you briefly indicate the level of savings that come from the reduction in delayed discharge over this period?

Derek Lindsay: Most of our costs are fixed, such as those of staffing. The reduction in delayed discharge has allowed us to meet increased demand with the numbers of Covid patients who have come to our hospital. We are currently operating at up to 90 per cent occupancy. There has not really been a cost saving. However, it is about utilising the available resources to the best effect. The balance can be more towards treatment in the community, where patients can be supported in their home, or in a more homely setting.

Hazel Borland: At this point, we are unable to put a value on the way that our communities have contributed to keeping residents and neighbours safe in the community. However, across our health and care system, with us and all our partners, our communities have absolutely pulled together to enable their own to stay at home and be safe there, and that has been a real benefit. Our communities have pulled together and worked alongside statutory services to enable residents to stay in their homes when, six or 12 months ago, that would not have been an option even with all the health and care services that we have.

A key learning point for us as we move forward and continue to build on our 10-year plan for caring for Ayrshire will be to learn the lessons of how our communities have worked together across our health and care system—with us and alongside us—so that we can really take that forward for the future and maximise that learning.

Brian Whittle: Another hot topic is our testing capacity. There is quite a lot of anecdotal evidence that patients are being asked to travel quite a distance to get a test, which suggests that our testing capacity is perhaps under a bit of pressure. Has there been an upsurge in the number of tests that have been carried out since schools reopened?

Hazel Borland: Absolutely. We have the capacity to undertake approximately 420 tests a day in our NHS laboratory. We focus that according to clinical need on asymptomatic key workers, symptomatic key workers, symptomatic patients and pre-operative work. We have also made a commitment to our partners on managing outbreaks in education.

There has been an increase in requests for tests through the single points of contact that we have established with our local authority colleagues to enable those tests to be co-ordinated. The significant increase has been through the portals rather than in the NHS setting. The NHS setting and our laboratories have recently experienced an increase in demand as a result of test and protect and our contact tracing, but there has been an increase in demand through the portal from our education colleagues as schools have gone back, which relates to testing for families, schoolchildren, teachers and others in the school setting. It is true that there has been an increase.

Brian Whittle: Do you think that there is adequate testing capacity in NHS Ayrshire and Arran to cope with the increase in demand?

Hazel Borland: We are undertaking an assessment of that. We are looking at what we currently use our NHS lab for and are undertaking a risk-based open assessment to understand what capacity it would give us to meet the clinical need for testing of symptomatic members of the public and symptomatic staff, as well as the contact tracing need, if we were to reduce the asymptomatic testing and surveillance that we undertake in that lab.

At the moment, working collaboratively with our portal colleagues and our Lighthouse facilities, we have sufficient capacity. The challenge will come if the capacity of the Lighthouse facility cannot meet the demand for testing for our care home colleagues and education colleagues. That will present us with an additional challenge, which will need to be met on a national basis.

Derek Lindsay: [*Inaudible*.] There are four steps in the testing process. The first is to take the swab, which, for example, the Lighthouse units in airport car parks do; the second is the analysing process in the labs; the third is the reporting of the results; and the fourth is the follow-on contact tracing. It is very important that the capacity of all four steps is aligned and that one of them does not become a bottleneck in the process.

We are very glad to have access to the Lighthouse unit, whereby people can book a test and get it there. We also have our own in-house drive-through testing facility The analysis in the labs is local and regional; analysis is done at the Lighthouse labs, too. We also have our results reporting hub.

Over the coming month or two, we will increase the staffing in all those areas. We have already started the process of recruiting people to do the swabbing, and we have increased staffing in the labs. We are also bringing in additional staff for the reporting of results, where people whom we have used in the past have been redeployed, and for contact tracing.

Emma Harper (South Scotland) (SNP): Good morning. I have a couple of questions about the innovative practices that have been adopted during the pandemic. Some of those have evolved, whereas others have been adopted rapidly after being pushed for for some time, such as the Near Me video consultation service and virtual review appointments. I am interested in hearing about any other innovations that were adopted during lockdown that will be retained or extended after the pandemic.

10:30

Hazel Borland: You are absolutely right. Our staff have been incredibly innovative to ensure that they can continue to provide services to patients and work together as colleagues across our health and care system.

A range of services have been digital. We have moved from having about 30 or 40 people who had the ability to network and work from home to having about 1,000 people who can do that. We have been able to increase the NHS Near Me consultations as well as using telephones. Those two ways of working will absolutely stay, because the ability of our staff to stay connected to their clinical networks from wherever they might be is of benefit to patients, and it enables staff members to work more strongly as a team across the health and care system.

Patients have told us that they have really enjoyed and liked the ability to have a telephone consultation or an NHS Near Me consultation. Such consultations have meant that they did not have the stress of having to drive to a facility and get parked. They did not have to think about going to a hospital facility. A number of our patients and their families have told us that they were quite anxious about that, so the ability to have a consultation from the safety of their living room was really welcome. I have no doubt that we will keep those innovations.

Increasing the range of public wi-fi across our systems has really helped patients and families to stay connected at a time when we have absolutely had to reduce the footfall across our hospital facilities in our health and care system. That has also been welcomed, and I have no doubt that we will keep that to enable our patients to stay in touch with their families and loved ones.

Other innovations have been to do with how clinical teams have worked together. For example, we have connected and co-located our clinical hub and our assessment centre with our out-of-hours and urgent care system. That has been an innovation for us, and we expect that we will continue that strong way of working after the pandemic.

Our range of clinical teams have innovated in how they deliver services to patients. They have been able to deliver online breastfeeding classes, musculoskeletal classes and cardiac rehab classes. I have no doubt that we will keep a range of clinical interventions, because we have had really good feedback from patients and families.

Emma Harper: The NHS Near Me service is a multidisciplinary tool that can be used, but are there particular specialties that it can work really well for, such as mental health? Is that something for which NHS Near Me can really benefit members of the public?

Hazel Borland: NHS Near Me has proved to be successful for a range of specialties including our mental health specialties. It has enabled our mental health community teams and specialties to stay in touch with patients. That also includes some of our surgical and medical specialties. Our clinical nurse specialists and our colleagues in the allied health professions have also found NHS Near Me to be valuable.

We have been able to use NHS Near Me to enable virtual visiting, rather than things such as FaceTime or Skype. We have found that it works really well for that.

Emma Harper: Has there been an assessment of the value of NHS Near Me or the other innovations? We know that people have been happier not to drive a 150-mile round trip in Dumfries and Galloway, for instance—Hazel Borland, as my previous nurse director, will know about that. A lot of time has been saved and there have been reductions in mileage, which is

important. Has there been an assessment of the value of the implementation of innovative solutions?

Hazel Borland: There is absolutely no doubt that using some of the virtual and digital ways of connecting with our patients has released clinical time. That is an element, but staff have also found that some virtual consultations, for example, have had more time dedicated to them, and patients have valued that. The approach has meant that the patient and their clinical team have been able to interact differently. That is another element.

We are in the process of understanding from our clinical teams and from patients and families what they value about that digital approach, what difference it has made and what they want to keep, as well as understanding what it has enabled our clinical teams to do better and differently, and whether they can do something additional because they are working in a different way. We are working through some of those impacts with the clinical teams.

There is no doubt that the reduction of travel, mileage and travel expenses will have an impact, and we will be able to measure the difference that that is making for our clinical teams and patients.

The Convener: Derek Lindsay wants to comment, but I am afraid that we cannot hear his sound. We will perhaps come back to him in a moment when we have the opportunity to do so. For the moment, I will move on to our colleague George Adam.

George Adam (Paisley) (SNP): My question follows on from Emma Harper's question on innovation. What lessons have been learned during the pandemic with regard to integration between health and social care? Did integration rise to the challenge of the pandemic, and what were the key challenges?

Hazel Borland: We have strong foundations that we were able to build on during the pandemic. We work incredibly closely with our health and social care partnership colleagues and our integration joint boards, and we were able to build on those strong relationships. The first lesson was that those relationships enabled us to work closely together and enabled our teams to remove the barriers.

Along with the chief executive and our medical director, I have been going around over the past three or four months talking to teams to understand what makes the difference for them, and that absolutely is about removing barriers. It is about enabling teams to work much more closely together and to work across the health and social care divide. They had been trying or had desired to do that but had perhaps been tinkering around the edges of it. The pandemic enabled them to remove any of those barriers and rise to the challenge. They have done that in a phenomenal way.

As we continue to go round talking to teams, we are keen to get their ideas on how we ensure that those barriers do not go back up again and that we enable our teams and colleagues to continue working in that way. I would say that, in Ayrshire and Arran, the way in which we work together as an integrated health and care system absolutely made the difference.

George Adam: That is interesting. As a former councillor and as an elected member of the Scottish Parliament since 2011, I have heard over the years that we need to break down barriers in various organisations and that that is key to the integration of health and social care. Why has it taken a worldwide pandemic to get to the stage where we are breaking down barriers?

Hazel Borland: That is a fair question. Across Ayrshire and Arran, we have a strong history of working well together across our health and care system. We consider ourselves to be a single health and care system. Some of the barriers that staff described were the small ones that they see at their level. For example, different teams are employed by different bodies, so there are slightly different working conditions and ways of working. Teams were already taking forward different ways of working and collaborations but, with some of the nuances and deliberations—dare I say it, some of the bureaucracy, although there is the due process to be worked through?—the pandemic enabled us to get through those more quickly and understand them differently and through a different lens. The pandemic has sped up a process and a journey that we were already on rather than being the reason why we were doing it in the first place.

George Adam: Can you highlight some areas in which you have improved the structures that are in place for decision making and allocation of resources? Has anything in particular changed, and will it continue to work in that way, because of what has happened?

Hazel Borland: From an NHS board perspective, during the pandemic, we swiftly established our emergency management team. One of the things that we have recognised as being of benefit in enabling us to make decisions swiftly and in an informed way is establishing silver and bronze specific groups, with the right people in them, to undertake bespoke pieces of work, understand the change that is required and pull together and enable delivery of the changes in a different way. We are looking at how we can keep that structure as an improvement, as it has worked across our health and care system. It has meant that staff across all our organisations have been in the room together, making decisions and

swiftly feeding them up without having to go through a process that potentially involves a number of committees. We have streamlined the process, and I anticipate that we will look at ways to enable us to keep that streamlined process so that we can swiftly make the decisions that we need to make.

We have that process across our health and care system, and we have had regular meetings with the NHS chief executive, our council chief executives and other partner colleagues in our local resilience partnership. We anticipate keeping the process for the foreseeable future, to make sure that there is collegiate oversight of issues that need to be taken forward and decisions that need to be made.

The Convener: I take it that delegating and empowering staff is part of the answer that you have given.

In its report in January, the ministerial strategic group described the criteria that IJBs and the health and care system should seek to achieve, and categorised them as red, amber and green. Where does NHS Ayrshire and Arran stand against those criteria?

Hazel Borland: I would need to get the detail from colleagues about the red, amber and green criteria, but, in terms of our strategic partnership, I am aware that, when we met yesterday, the criteria that we were looking at were all green at that point. I expect that the individual IJBs would agree that that is where we are at this time.

The Convener: Thank you. The further detail that you describe would certainly be helpful, so if you could let the committee have it, that would be appreciated.

Finally on that subject, can you indicate whether IJBs in Ayrshire and Arran received any allocation of funding in addition to that made for social care by the Scottish Government?

Hazel Borland: I will pass that question to Derek Lindsay to answer. He has a level of knowledge on the matter that I think would be beneficial.

The Convener: You may indeed, but we will have to come back to Derek Lindsay a little later.

Donald Cameron (Highlands and Islands) (Con): My questions are about financial stability. I do not know whether Derek Lindsay is available to answer them, as they are essentially about funding. I am happy to ask them, but they are probably not suitable for Hazel Borland.

The Convener: We are still having some technical challenges with Derek Lindsay's connection. If you begin your questions, Hazel Borland can address the general points—I am sure that she will have a grasp of those—and, if we need more detail, we will come back to Derek Lindsay.

10:45

Donald Cameron: We know that NHS Ayrshire and Arran received £14.7 million from the Scottish Government in the previous budget year, 2019-20. Does the health board anticipate requiring additional Scottish Government financial support in 2020-21? If so, how much?

Hazel Borland: I think that we would anticipate requiring additional funding this financial year, primarily due to the Covid situation. Derek Lindsay has already described the additional funding that we received and said that he anticipates that we will need £67 million to the end of the year.

We have a financial recovery plan, and we continue to liaise closely with Scottish Government colleagues to ensure that we are on the trajectory, as much as possible, to achieve what is set out in the financial recovery plan. I can advise that we will definitely not be in financial balance at the end of the year. We are working closely with Scottish Government colleagues to understand our quarter 1 analysis and to ensure that, outwith Covid, we still have our eye on the financial requirements that we were aiming to achieve. We are also aiming to liaise with Scottish Government colleagues on whether we are on a trajectory to deliver the financial requirements in the context of Covid.

We continue to work very hard with Scottish Government colleagues. Along with other boards in Scotland, we have received a number of additional allocations to enable us to continue to deliver services, which has been incredibly welcome. That is probably as much detail as I can provide at this point.

Donald Cameron: Does the board expect to achieve the aim of breaking even over a three-year timeframe, in line with the change of approach that was announced by the Scottish Government in 2018 that allowed such plans to be made over three years?

Hazel Borland: That is our absolute ambition. We are working incredibly hard to ensure that we are sighted on that, and that we have realistic and deliverable ambitions and trajectories to achieve our financial targets that do not impact on our service delivery. That means having conversations across our whole health and care system about how we do that and ensuring that we make the best use of innovations.

We are focusing on making strong connections between our financial planning over the three years and our 10-year vision and our caring for

Ayrshire plan, because those two things link closely together in relation to delivering health and care services in the most efficient, effective, safe and person-centred way. We are also making sure that, over the three-year period, we are on track to deliver the financial commitment that we have stated that we will deliver. That is our absolute ambition.

Derek Lindsay: I am sorry that the committee could not hear me previously. Can you hear me okay now?

The Convener: Yes, we can.

Derek Lindsay: Our three-year financial plan, which was submitted to the Scottish Government at the end of March, indicates that we will break even within that three-year period. We have been on a trajectory of reducing our deficit, and that is expected to continue.

We are learning the lessons from the impact of Covid and the redesign that has happened quickly. Hazel Borland mentioned details on the Near Me service, out-patients and how we deliver such services. We hope that the redesign of how we handle urgent care and community hubs will also give us benefits to allow us to have a sustainable system for the future.

Donald Cameron: My final question is about the effect of the pandemic on the financial trajectory. Can you give any more details about that? In particular, I am interested in the delay to operations and other standard care that the pandemic has caused. In the last week, we saw the national picture of waiting times and saw that a lot of operations are being delayed. Will that have a financial impact?

Derek Lindsay: Our staffing, diagnostic and theatre capacity is reduced as a result of Covid and for the period of Covid. Although many staff were redeployed from those areas to deal with front-line services during the initial three months or so, we need to see how things progress during the year. We are in a remobilisation phase in which surgical and out-patient services, for example, are restarting. However, we have a big backlog and our capacity to reduce that backlog is extremely challenging.

Within our remobilisation plan, we have asked for additional funding and—indeed—we have already received some additional funding from the Scottish Government. An example of that is the funding that we received for a mobile magnetic resonance imaging scanner, which is located at Ayr hospital and which increases our capacity. We will also utilise capacity at NHS Louisa Jordan and Golden Jubilee national hospitals.

However, although we have a plan, we will not be able to address the whole of the backlog, because we will be trying to balance the capacity that we have to meet our current referrals and so on in the first instance. We are talking about the long term in relation to the recovery of the performance targets that Mr Cameron mentioned.

The Convener: Have you received assurance from NHS Scotland about the additional one-off costs of the Covid pandemic being covered and met?

Derek Lindsay: Yes. We have received assurance from the Scottish Government that the additional costs of Covid-19 will be met. A number of things are centrally funded. For example, testing kits and personal protective equipment for NHS workers are provided free of charge. That cost is met centrally.

The additional costs of our extra capacity in ITU and Covid beds—and any other costs relating to that—will be covered by the Scottish Government. That is built into our financial reporting to our board on a monthly basis.

The Convener: Hazel Borland indicated that you would be looking for further additional financial support this year. What will that amount to, given what you have said about items that will be covered in any case?

Derek Lindsay: The financial part of the remobilisation plan indicated that £67 million is required. Around half of that relates to community-based costs, which include sustainability payments to care homes and the cost of personal protective equipment for our social care workers in a care-at-home context. It also includes the costs of unachieved efficiency savings for both integration joint boards and ourselves, because we have not been able to take forward some of our planned efficiencies this year. That total of £67 million incorporates all those things.

The Convener: Before I call my next colleague, I go back to the questions that were put by Emma Harper regarding Near Me and other interventions. I invite Derek Lindsay to respond to those and, in particular, to assess the value of those interventions and their on-going importance.

Derek Lindsay: I will simply build on what Hazel Borland said. We have had technology-enabled care in place for some time, but it has proved its worth and we wish to take it forward. It is about using technology to support patients in their own homes. Therefore, patients with chronic obstructive pulmonary disease and other health issues can be supported, using technology-enabled care. From an administrative point of view, the use of Microsoft Teams has saved staff time and travel costs, whether that is attending national meetings or working across sites, so that has been a benefit to us.

David Torrance (Kirkcaldy) (SNP): My questions are on the impact of Covid-19 on the 2020-21 budget. On balance, over the whole financial year, do you expect additional costs from Covid-19 to be offset by the reductions in expenditure elsewhere?

Derek Lindsay: The straightforward answer to that is no. The longer answer is that the additional costs incorporate a range; in my previous answer, I mentioned a number of social care costs, such as sustainability payments to care homes, personal protective equipment and having to recruit extra staff to do contact tracing, tests and analysing the tests in labs. However, there are offsetting savings in costs that we have not had to incur, such as supplies costs. Because we have not been doing hip and knee operations, we have saved the cost of those implants. The redeployment of staff to cover other areas is offsetting the additional cost of the extra beds that we have had to open. However, as we move forward with remobilisation, those staff are now working back in their core areas, such as out-patient, surgical and theatres, so there is a net cost increase, because we are having to recruit additional staff for the remainder of the year to carry out the additional functions that I mentioned.

Hazel Borland: I will build on what Derek Lindsay explained. We are cognisant of additional issues across the health and care system that might impact on the budget in the short and long term. We are thoughtful about the impact on children and families across our community; we need to meet their health and care needs from a physical and mental health perspective.

We are thoughtful about learning from other countries that have been through the pandemic scenario and had a rise in public protection activity; we need to make sure that we can meet that potential increase across our systems. We are also thoughtful about the additional stretch of the infection prevention and control requirements that we will need to address differently on a long-term basis. In those three specific examples, we are thinking across our health and care system about the impact that meeting our community's needs might have on the budget.

David Torrance: Can you put a financial figure on those additional costs over the year? Do you expect the Scottish Government to provide money for all those additional costs?

Derek Lindsay: Yes. In our financial plan that we submitted to the Scottish Government along with our remobilisation plan, the additional costs for this year—net of the areas where we have been able to reduce costs—are £67 million. We expect the Scottish Government to provide that funding from Barnett consequentials that it has received from the UK Government for that situation.

Hazel Borland: I echo what Derek Lindsay said. We have made a measured judgment about what we need in the context of Covid to continue to deliver our services, recover and restart other services, and about the additional workforce needs. We will also need to look at the potential health impact across our system and communities. At this point, there is an anticipation that the Scottish Government will meet the needs that we have outlined in our financial plan that sits alongside the remobilisation plan.

11:00

Sandra White (Glasgow Kelvin) (SNP): The questions that I was going to ask about finance and budgetary outcomes have all been answered, so thank you for that.

I am pleased to hear that the innovative changes that you have made will continue in the future. Now that you are working more closely with IJBs and local communities and lots of barriers have been broken down, does the board have plans to increase their involvement in decision making on budget saving?

Hazel Borland: Derek Lindsay might want to come in but, in Ayrshire and Arran, we are already well connected and collegiate in our decision making across our health and care system. For example, our three partnership directors are part of our health board senior management team. We make decisions as a collective. We are clear about the decision making on budgets rolling through our IJBs and our NHS board in the sequence that it needs to. We ensure that the governance elements are met, and we are inclusive of everyone who needs to be sighted on, and participate in, those decisions.

For budgetary decisions that need to have directions from the IJBs, the health board and the council, we are trying to be much stronger so that we work closely as that triumvirate, as the integration of the health and care system was designed to work from a governance perspective.

We already work closely on any budgetary decisions. Derek Lindsay may have a view on what that needs to look like from a governance perspective and on any limitations that there might be from a legislative perspective.

Derek Lindsay: I agree with Hazel Borland. We align our budget-setting process, and section 95 officers from each of the three Ayrshire and Arran IJBs are part of our groups that look at cost pressures for the future year.

One area that is slightly different for the NHS in comparison to the IJBs or health and social care

partnerships is the provision of personal protective equipment. For the NHS, PPE is purchased across the whole of NHS Scotland by NHS National Services Scotland through the national distribution centre, and is therefore received free of charge. The default position for our health and social care partnerships is that they are expected to buy PPE for their staff, as are care homes. However, there is a safety net: personal protective equipment can be provided if those supply chains do not work.

A national option appraisal is going on to determine the best way to deliver that, because our council and health and social care partnership colleagues are finding that the cost of personal protective equipment has gone up significantly. There may well be benefits in purchasing the equipment on behalf of us all. For example, our health and social care partnerships estimate that they will spend about £5 million on personal protective equipment this year. Opportunities to reduce that amount through national procurement are being looked at.

Sandra White: That is an interesting point. The issue of schools going back and people being tested was mentioned earlier. An issue that has been raised with me is whether schools should provide protective masks for pupils and teachers. Given what you have just said, do you have any thoughts on that? That would be an interesting point for the committee to highlight and to seek clarification on.

One reason why I am asking about schools is that I am conscious that some kids will wear designer masks while others cannot. It would be good if schools could give out masks, so that no kids are disadvantaged if they cannot afford a designer mask. Has the issue been raised with you in your meetings with the Convention of Scottish Local Authorities and local councils?

Hazel Borland: I am not aware of discussions on that interesting issue. In the NHS, we expect patients and families who come into our settings to bring their own face covering or mask. However, if they do not have one, we have them available as people enter the building.

I am not sure what the discussions have been with education colleagues about how that would translate into the education setting, but it could be helpful to have such a conversation across schools, for the reason that you gave.

Sandra White: I ask the committee to look at that idea and consider Hazel Borland's comments. In addition, I was not aware of the separate budgets and different ways to get face masks, which Derek Lindsay mentioned. It would be good if the committee could follow up on that, too.

The Convener: Finally, I want to ask about the impact of funding and the balance between hospital and community care. Have the changes resulting from the pandemic led to any shift in the balance of care between hospital and community care? What impact will any shift have on the funding of IJBs and, in particular, on set-aside budgets?

Hazel Borland: We have realised that, during the past five months, there has not been a straight-down-the-line shift in the balance of care. We have made sure that the right care is being provided in the right place at the right time by the right person. Across a variety of settings, sometimes, it is right and proper for a person to come into hospital and, sometimes, it is right and proper for them to be in the community.

One of our biggest learning points has been across our primary and community care setting and how we have worked with primary care and GP colleagues to enable them to continue to provide services during this time. How we provide that care and, indeed, how we provide urgent care and schedule it in a different way in our community, has been a big element of our learning.

At this time, it is not so much about shifting the balance of care; it is more about making sure that the person who needs the care gets the right care in the right place at the right time. It is also about making sure that we progress that in our 10-year vision and caring for Ayrshire programme, which is about ensuring that a significant amount of care is provided in the community and that we have the connections right.

Derek Lindsay: East Ayrshire health and social care partnership is the lead partnership for our Ayrshire unscheduled care service, which includes out-of-hours doctors. The partnership has also been delivering the community hubs for us during the pandemic. Their future is seen as significant for managing the demand on our emergency departments. That is a potential shift.

As Hazel Borland mentioned, instead of people turning up at an emergency department, we are trying to triage in advance of that and then schedule those people who turn up to an emergency department. That is one tangible shift on which we are doing a lot of work to consider how we progress it.

The Convener: Is there an impact on your set-aside budgets?

Derek Lindsay: The set-aside budget is the element of our acute budget associated with certain specialties, so, by definition, the set-aside budget is in acute services. Therefore, I think that the impact will be marginal.

I have just described measures to do with emergency services. They are part of the set-aside budget. If less were to be required of the emergency department and more of the community hub, that would be a potential shift, but I think that that would be at the margins.

The Convener: That is helpful.

I thank both our witnesses, who have answered a range of questions. Hazel Borland has offered to provide us with a little more detail, and, no doubt, we will write to you following this session.

I suspend the meeting briefly in advance of the next agenda item to allow other witnesses to join us.

11:11

Meeting suspended.

11:15

On resuming—

Subordinate Legislation

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 9) Regulations 2020 (SSI 2020/242)

The Convener: We will move first to agenda item 3, which is consideration of a made affirmative instrument. After considering that instrument, we will go back to agenda item 2, which is consideration of two negative instruments.

Agenda item 3 is consideration of SSI 2020/242. Colleagues will recall that the regulations are laid under section 94(1), on international travel, of the Public Health etc (Scotland) Act 2008. That act states that such regulations should be subject to the affirmative procedure, but that the affirmative procedure will not apply

"if the Scottish Ministers consider that the regulations need to be made urgently".

In such situations, section 122(7) applies. It sets out that

"emergency regulations ... must be laid before the Scottish Parliament"

and that they will

"cease to have effect at the expiry of the period of 28 days beginning with the date on which the regulations were made unless, before the expiry of that period, the regulations have been approved by a resolution of the Parliament."

It is for the Health and Sport Committee to consider such instruments and to report to Parliament accordingly.

We are joined by Humza Yousaf, the Cabinet Secretary for Justice, and his officials. I welcome the cabinet secretary, who is accompanied by 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.

We had a full evidence session with you last week, cabinet secretary, and I know that you will be preparing a response to the questions that we put to you then, so I do not intend to rehearse those questions in any detail. However, it would be good if you could outline the impact of the regulations and tell us why they are being laid at this time.

The Cabinet Secretary for Justice (Humza Yousaf): Good morning. I hope that everybody is in good health.

On the back of last week's lengthy session, I received your letter, and I intend to give you a detailed response. If you need further clarification on anything that is in that response, I will be more than happy to provide it, in writing or by appearing in front of the committee. I expect that such appearances will be a fairly regular occurrence, given the nature of the virus and the speed at which cases of it are, unfortunately, progressing in a number of countries.

In relation to the regulations in front of us, the committee will remember that we receive data from two sources to help us to make our assessment of whether a country should be removed from or added to the list of exemptions from quarantine: an analysis from the joint biosecurity centre—the JBC—which looks at a range of data; and a risk analysis by Public Health England. We have got into the pattern of receiving that data generally on a Wednesday, and on Thursday having a conversation among the four nations and coming to an agreement on which countries should or should not be removed from the list.

In the case of the regulations in front of us, what we saw in France in particular was a challenging situation, in which the number of cases rose in the space of a few days to a worrying level. We faced a challenge in that we were reliant on the French Government producing that data, which it did quite late in the evening. We had to make a decision. We had a four-nations call at about half past 9 that night, if I remember correctly, and we made an announcement at about 10 o'clock or just thereafter. That was because we were so reliant on that data.

In short, particularly for France and the Netherlands, the rise in the number of cases per week was worrying, the increase in the number of positive tests was deeply alarming, and the general trajectory in those countries gave us enough cause for concern to remove them, as well as the other countries that are mentioned in the regulations, from the list of exemptions.

The Convener: Thank you. If colleagues have questions, I ask them to indicate that to me.

Cabinet secretary, I presume that you will continue to monitor the numbers from France and the other countries that you referred to. I am sure that we will come to this during a later meeting but, in recent days, we have seen countries being added to the list of exemptions and then quickly being removed from it. Is that simply a function of the process that we are engaged in? What is your view of the countries that we are dealing with today? Will you continue to monitor them in the same way, with a view to reintroducing exemption when it is safe to do so?

Humza Yousaf: That is a good question, convener. My honest answer—I hope that I have been very clear about this publicly—is that, even if a country is added to the exemption list, so that people who come back from it do not have to quarantine, that situation can change rapidly. We have seen that with a number of countries.

Of course, there have been clusters in our own country—including in the region that you represent, convener, so you know that well. Situations within a country can change within a matter of days, let alone the space of a week. The very strong caveat from all four nations around any country being added to, or even removed from, the list of exemptions is that there is always a risk. When you are travelling internationally in the midst of a global pandemic, the situation might change in a matter of days, let alone in a week.

We continue to watch and monitor the countries that are mentioned in the regulations, and we also get risk analyses and data on a number of countries about which we have some concerns.

The Convener: I am sure that what you describe is correct, but the process has tended to be that when a country is to be removed from the list of exemptions, one, two or three days' notice is usually given—for example, people who are travelling from the end of the week will be subject to the regulations. That is clearly convenient for people who are making return journeys within that timeframe. From a public health perspective, are you satisfied that that is the correct approach when countries are removed from the list of exemptions?

Humza Yousaf: Again, that is a good question. We have got to a process now whereby, generally speaking, things can change because we will always act in the best interests of public health. Generally, we tend to have the four-nations call at midday on Thursday, and we will make a decision and an announcement at 5 o'clock on Thursday. Usually, the regulations will come into force on the following Saturday at 4 in the morning. That is the pattern of what has happened in the past couple of weeks.

However—this is a really important caveat—that will not always necessarily be the pattern. If data shows from a Scottish perspective that the importation of cases from a certain country is causing us alarm, we reserve the right to move quickly because of our public health imperative. There is a fine balance to be struck between ensuring that we bring in such regulations as quickly as possible once we are alerted to a possible dangerous situation in another country,

and ensuring, at the same time, that there is at least a little bit of time for Border Force, for example, to be able to put that decision into operation. That is why the window between making an announcement on the Thursday at 5 o'clock and the regulations coming into force on the Saturday at 4 in the morning is quite narrow.

We will tend to keep that gap between announcement and implementation as narrow as we possibly can because, again, we would not be making these decisions if there was not a public health risk.

The Convener: No other member has indicated that they wish to ask questions of the cabinet secretary or his officials, so we will move on to agenda item 4, which is the formal debate on the made affirmative SSI on which we have just taken evidence. I remind members and others that this is no longer a question session, so it is not for officials to take part or for members to put questions to the minister; it is simply a formal debate, to which members may or may not wish to contribute.

I invite the cabinet secretary to move motion S5M-22436, in his name.

Motion moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 9) Regulations 2020 (SSI 2020/242) be approved.—[*Humza Yousaf*]

Motion agreed to.

The Convener: I thank the cabinet secretary and his officials for their attendance.

Scotland Act 1998 (Agency Arrangements) (Specification) (Coronavirus) Order 2020 (SSI 2020/776)

Scotland Act 1998 (Agency Arrangements) (Specification) (Coronavirus) (No 2) Order 2020 (SSI 2020/777)

The Convener: We now move to agenda item 2, which we skipped over earlier but which remains before us for consideration. It is on subordinate legislation, and is consideration of two negative instruments.

In July, Jeane Freeman, the Cabinet Secretary for Health and Sport, wrote to the committee and provided a series of updates on the digital response to Covid-19. That included working with the UK Government on the potential for an app to be developed by the UK Government and to be used throughout the UK. The instruments put in place the formal arrangements to allow that to happen by enabling an agreement to be reached between the Scottish Government and UK ministers on the operation of such an app within Scotland by UK ministers. They are not of course the agreement itself; they are simply the legislative framework to allow that to happen.

Do members wish to comment on the instruments?

Sandra White: I note the letter and that the cabinet secretary has recently agreed in principle to such an approach. I am not against the SSIs, but I want to ask for clarification. We are told that

"The app is intended to further extend the speed and reach of contact tracing in England and, should Scottish Ministers so choose, within Scotland as part of NHS Test and Protect."

There have been newspaper reports stating that people in England who have used the app have been asked for their bank details. I am concerned about that, so I would like some clarification on the issue, perhaps in a letter.

I believe that, in July, a question was asked of the First Minister with regard to Scotland having its own track and trace app, which would be similar to or the same as that in the Republic of Ireland. I also wonder where we are on that.

I seek clarification on those two points with regard to the SSIs.

Emma Harper: Like Sandra White, I do not oppose the SSIs, but I am interested in the language around impact assessments. We are told:

"A full impact assessment has not been produced for this instrument as no, or no significant, impact on the private, voluntary or public sector is foreseen."

I would like clarification on that language.

The Convener: Sandra White and Emma Harper have asked us to seek further information, but I think that they both said that they are happy to make no recommendations in relation to the instruments. Clearly, we can write to Jeane Freeman to seek clarification in any case. We could delay our consideration of the instruments pending a response, but I think that the members have indicated that they do not want to do that and are simply seeking information. I see that Emma Harper agrees.

Therefore, given the agreement to write a letter covering those points and the other comments from members, does the committee agree to make no recommendations on the instruments?

Members *indicated agreement.*

The Convener: We will inform Parliament accordingly. We now move into private session.

11:30

Meeting continued in private until 11:58.

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