OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 8 September 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 8 September 2020

CONTENTS

	Col.
PRE-BUDGET SCRUTINY 2021-22	1
SUBORDINATE LEGISLATION	31
Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 10) Regulations 2020 (SSI 2020/252)	31

HEALTH AND SPORT COMMITTEE

22nd 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:

Eddie Fraser (East Ayrshire Health and Social Care Partnership)
Vicky Irons (Dundee Health and Social Care Partnership)
Judith Proctor (Edinburgh Health and Social Care Partnership)
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 8 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 22nd meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton and Donald Cameron.

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 and 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 of Covid-19 on health and social care in the current financial year. 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 fourth in this series of meetings, we will hear from chief officers of integration joint boards. I welcome Judith Proctor, chief officer, Edinburgh health and social care partnership; Vicky Irons, chief officer, Dundee health and social care partnership; and Eddie Fraser, chief officer, East Ayrshire health and social care partnership.

Members will ask questions in a pre-arranged order, as we usually do when we hold online meetings. As ever, it will be helpful for members to indicate when they have reached the last of their questions to assist broadcasting colleagues. Likewise, if witnesses wish to answer any additional questions, please indicate that.

Clearly, Covid-19 has changed many things about the way in which we all work, not least in the areas for which health and social care partnerships are responsible. Did the existence of health and social care partnerships assist with the response to the pandemic? If so, in what way?

Judith Proctor (Edinburgh Health and Social Care Partnership): Good morning and thank you for the opportunity to appear before the committee.

My answer to that would be a resounding yes. The integrated approach—having integrated teams and being able to mobilise across the whole system with our partners—was a significant contributor to our ability to mobilise our workforce across our city and Scotland. Some of the interorganisational barriers disappeared and we were able to move our staff across areas to support those areas that we knew would have significant pressures. We were able to take a holistic approach to how we supported people at home and in care homes. The way in which we worked with secondary and acute care demonstrates our ability to move swiftly.

Vicky Irons (Dundee Health and Social Care Partnership): Thank you for the opportunity to comment. I endorse Judith Proctor's comments about the initial response. The foundation of partnership that already existed across Dundee benefited the city and the rest of Scotland, particularly at the outset of the pandemic, when Covid-19 was presenting in communities and not necessarily in the way we predicted it would through a huge surge in hospital-based activity.

We depended on the support of our local authority colleagues in being able to bring together new services that needed to be configured extremely quickly, and on the wider partnerships that are configured in our integration joint boards, such as with the voluntary sector, to ensure that we provided essential services, particularly for those who were shielding and those with complex needs.

Without doubt, we have seen a large transformation of the kind of care that we can provide in community settings as a result of that. If we had not had the foundation of those partnerships in place in Scotland, our response would have been extremely different.

Eddie Fraser (East Ayrshire Health and Social Care Partnership): Good morning. I will build on what my colleagues have said, using the example of shielding that was just given. I lead for the council and NHS Ayrshire and Arran on shielding. We were able to join up services to quickly ensure that people who were shielding got the essential practical supports with shopping, prescriptions and so on, and that there was no differentiation between the various strands of that support.

In other areas, we were able to build on long-standing work. For instance, we had weekly meetings with care homes that enabled us to quickly bring in public health and other professionals when that was required, which has

meant that the relationships have been strengthened rather than being fractured.

Another issue that I would reflect on is that, if we were not sitting in an integrated environment, there would have been a risk of people bickering over budgets and who was going to pay for what. However, essentially, in local communities, it did not matter, because the chief officers were responsible across the health and care budgets, which meant that they were able to take decisions and act under the auspices of the IJB.

Across the system, IJBs have been essential as an interface between the national health service, councils and, importantly, the independent and third sectors.

The Convener: Judith Proctor, what have been the key challenges for integration authorities, and has the experience of the pandemic changed your perspective on what the challenges are for integration authorities in general?

Judith Proctor: Some of the key challenges that we saw for the integration authority disappeared during the period. Early on, we worked to ensure that we had good and appropriate governance in the IJB so that it could undertake its strategic decision making. In large part, the responses that we put in place were operational through the health and social care partnership. We need to make a distinction between those two things. Our IJB enabled emergency decision making to be undertaken by me, in partnership with the chair and vice-chair of the IJB.

As Eddie Fraser has said, chief officers are responsible through the NHS and the local authority, so we work closely with incident management teams and gold command so that we can make decisions quickly. Quick and appropriate decision making was of the essence at the height of Covid, and some of the factors that make it difficult to make speedy decisions disappeared at that time.

As has been touched on, some of the issues around mobilisation plans and funding were simpler, because we were able to make decisions knowing that funding would be made available for us to ensure that those services and responses could be put in place. That also ensured that some of the usual challenges that we face were not in place during the period.

I hope that that addresses the question that you asked, and I am happy to follow up on any issues that you have.

The Convener: I think that that covers it.

Vicky Irons, we have heard from Judith Proctor and Eddie Fraser about the work that is done between integration partners. Is it also your experience that there has been effective joint working between health boards, local authorities and IJBs to ensure prompt action, and is it your experience that partners have been represented equally throughout the pandemic?

Vicky Irons: My experience reflects Judith Proctor's comments. Our pandemic response and emergency measures have, in some ways, liberated the system to get on and do the right thing—that is an expression that was used by one of my colleagues recently. We have definitely witnessed a level of integration that was not present prior to the pandemic response or, certainly, was not happening at the pace at which change was enabled during the early weeks of the pandemic.

As Judith Proctor has also highlighted, we have very robust processes in place in terms of our command centres within the IJBs and the participative role that we play in the NHS board arrangements and the local authority arrangements. As a collection of IJBs, we were also in regular contact with Scottish Government officials and other key agencies, such as Public Health Scotland, throughout the process. That has cemented some of those relationships and enabled the system to develop one response, which was entirely necessary under the circumstances.

The Convener: Eddie Fraser, has the experience of the pandemic highlighted any areas for improvement in the structures that are in place for decisions making and the allocation of resources?

Eddie Fraser: Some issues with regard to the allocation of resources and other things that the other witnesses have reflected are down to the relationships between the organisations. If the relationships between the health board, the council and the IJB are strong, some things that could cause delays do not cause delays. Because of trust between the organisations, they just go ahead and do the right thing. Sometimes if people know that something needs to be done, they go ahead and do it.

I certainly felt at the start that miscommunication with the wider membership of the IJB was an issue. Until we got things such as videoconferences up and running, that was difficult. When it comes to our work as visible leaders, whether in care homes or for people with learning disabilities or care-experienced young people, not being able to see and hear from those people easily at the start was difficult.

There were bits at the start of the response that we had to learn from, and we had to learn how to communicate differently with people. I dare say that we will have to continue to learn that. The

worry is those who have the most difficulty accessing us because of our arrangements; we are not able to speak to them enough. We are having to learn different ways to communicate and ensure that we continue to be inclusive.

It is necessary for us to follow a command and control model when we are in the middle of a crisis, but it is also necessary, as we go forward, to make sure that everything that we do is informed by our communities and is for our communities.

The Convener: We heard from Vicky Irons about co-ordination with the Scottish Government. Judith Proctor, what is being done to ensure that positive lessons are retained once the pandemic is over? How are experiences being shared across the country?

Judith Proctor: The committee will be aware of the several pieces of work that we have done on that in partnership with other organisations. A lessons learned process was undertaken with colleagues in the Scottish Government in July or August. I think that Elinor Mitchell's letter to the committee last week shared with you the report that resulted from that. It has been a valuable piece of work. It focused on lessons learned in relation to delayed discharges, but it also looked across the broader spectrum of our experience in health and social care partnerships over the pandemic—what worked well, what we were able to mobilise quickly, what some of the issues were and how we can retain those lessons in the future.

As a group of chief officers in Health and Social Care Scotland, we partnered with the British Medical Association to do some work on the lessons learned in primary care, such as primary care's significant response early on through Covid centres and the way in which it has retained services using different modalities and working through things such as Near Me. That has been a valuable piece of work, and we have shared it across our network.

I believe that we are all individually doing a lessons learned capture, too. In Edinburgh, we started capturing the lessons that we were learning quite early—from around April. That information has been pulled together and we are disseminating it throughout our partnership.

The group of chief officers in Health and Social Care Scotland is a very strong and supportive collective that focuses on sharing what we are learning as we go. It has been a feature of the network from the get-go, and it has been enhanced and accelerated throughout the Covid response. We met daily with the Scottish Government throughout the early part of the pandemic by teleconference. We are shaping our future agenda based on the lessons that we take from Covid that we implement across Scotland—quite a lot has been done in that area. As a network, we do some work with the the King's Fund that relates to our personal experience of leading through this. That work is on-going.

10:15

The Convener: Vicky Irons, can I ask you to cast your mind back and tell us how early you and others were able to begin preparing for lockdown? Did you have a matter or days or weeks to be ready, and what planning took place?

Vicky Irons: Although we have not necessarily benefited from being able to predict the scale and length of this pandemic, we have benefited from having previously exercised plans for other pandemics, such as bird flu. We therefore already knew the sequence of events in which services might change and how we would prepare in the event of a lockdown or large staff absences. In essence, we had a fair level of warning to be able to prepare our care and service provision for the eventuality of lockdown.

For some of the elements of that—such as shielding, provision of care and supplies, including medicine supplies, and a lot of other practical things—we had only a number of days or potentially a week's notice to get arrangements into place. However, being in the position that we are in, particularly with the logistical expertise that we had from local authority colleagues, we were able to respond very quickly and had already prepared how we would provide care if buildings were closed and how we would provide medicines and other supplies to those who were most vulnerable. Most of those elements fell into place quite quickly.

Sandra White (Glasgow Kelvin) (SNP): I will follow on from the convener's questions about additional funding for health and social care. The Scottish Government has committed £100 million to that; the first tranche was £50 million, which was followed up by another £50 million.

Judith Proctor mentioned in her comments to the convener that the funding that was made available was positive. However, the written submission from Edinburgh health and social care partnership raises concerns that the funding that has been received is not sufficient to meet the full cost of paying the living wage uplift. The report on "Lessons Learned from Reducing Delayed Discharges and Hospital Admissions" also raised concerns. Are the witnesses confident that resources will be made available to meet the additional costs that have been identified in respect of health and social care services for which the IJBs have responsibility?

Judith Proctor: We have worked closely with our Scottish Government, health and local authority colleagues in relation to the costs that are additional to our core costs as a result of Covid. We are capturing those as we go.

We have resolved the issue in Edinburgh in relation to the living wage, and we are working on being able to provide that with our partners. The IJB agreed to that on 24 August, and it has been agreed by the finance and resources committee of the City of Edinburgh Council. The matter is now going to the full council to be discussed, and one anticipates that it will also be agreed there. Therefore, the living wage aspect has been addressed in Edinburgh and we look forward to being able to pay that to staff.

Sustaining Covid costs will be a real challenge. Our job as health and social care partnerships is to be clear about where our additional costs are being incurred and ensuring that, in partnership with the councils and the NHS, we capture that and discuss it with the Scottish Government.

Some of the challenges around the sufficiency of funding relate to the unknowns of Covid. We do not know for how long the pandemic will go on—the incidence of the virus is increasing in some communities, so the length of time that we will be working in the current circumstances is an issue. Some of the issues of sufficiency relate to the unknowable aspects of living with Covid as we move through the route map.

Sandra White: Do the other witnesses have comments on that particular aspect of the responsibility of health services?

Eddie Fraser: There are a number of issues around funding. As an IJB, we anticipate that the total extra cost to us will be £9 million—just now, the net cost is sitting at about £6 million. It is not all direct IJB costs, because we run many pan-Ayrshire services. For example, that amount includes the cost of the Covid hub. Those costs are all included in the mobilisation plans that have been put to the Scottish Government. Later this afternoon, we have a feedback session with the Government on that subject.

We have to consider a number of other requirements. We need to ensure that the sustainability payments to our social care partners can be sustained. If they are not sustained, the people who receive those services will end up with poorer care, and there will be a greater cost to the public services that have to pick up that work. How we work together to address that will be an issue for us.

Another issue—it is one of the unknowns that Judith Proctor spoke about—is what the pandemic will mean for how long each individual social care visit takes. For example, carers will need to spend time putting on and taking off personal protective equipment while still providing people with the same level of care. The same applies to our community nursing services. In those areas, it is taking longer to deliver the usual interventions, and we need to work out what that will mean for us.

Another important issue concerns the changes in the way in which services are provided. At present, day services for adults and older people are limited, and we are having to move to a care-at-home model, which is often much more expensive to deliver, in order to ensure that people receive the services that they need. The provision is not the same, however, because people do not get the same amount of social interaction. As we move forward, we need to look at how we can deliver social interaction for people who are getting care in a different way.

Those will be some of the costs to us. There are the known knowns, and we are all working through those with our mobilisation plans. However, there are also a number of unknowns, and those are some of the biggest concerns for us just now.

Vicky Irons: To build on the comments from Eddie Fraser and Judith Proctor, I say that the issue for us as we move forward is the cost of remobilisation; there has been extensive work in connection with that. The costs for Dundee City Council are sitting at just over £16 million, and we have had about £1.5 million of the national funding released so far. We are entirely dependent on the assurances that were given at the outset of the pandemic about the ability to respond to that level of financial risk. I highlight that a series of papers have been put forward in our local systems that outline the details of that position—they might be of interest to the committee.

An additional issue is what happens during the next period of the Covid response and how we balance that with the natural rise in demand that occurs throughout the winter season. I am thinking in particular of the increase in the flu immunisation programme, and of other immunisations that we hope will come on stream.

More than that, there has been a sea change in respect of those people who now require capacity for community-based care. That aspect has changed completely throughout the pandemic. People are confident about asking for their care to be provided, wherever possible, in their homes or in community settings. As an entire system, we need to be able to respond to that level of demand, and to retain some of the new developments that have emerged to enable us to do so.

Beyond that, we are now all seeing signs of a significant increase in demand for support for

mental health issues. There is a huge level of anxiety across the population, which will undoubtedly have an impact on not just mental health but physical health in the years to come, so we need to prepare ourselves adequately to respond to that. Inevitably, there will be a resource implication for us all because of the level of demand. We need to understand the risks and, to an extent, undertake a fresh strategic needs assessment so that we can plan accordingly.

Sandra White: A lot of hard work is being put in, and I thank you all for the work that you are doing.

We are talking about responses. What are the mechanisms for passing on resources to social care? You have said that you have had Zoom meetings and so on. When you have spoken to the Scottish Government or whoever is giving you the money, have the responses and allocations been provided quickly enough to cover what you are asking for?

Judith Proctor: One of the challenges that has been raised by our colleagues in the third and independent sector is the speed with which the sustainability payments have been made. The payments have come into our organisations and been passed on through the NHS into local authorities. Our chief finance officer colleagues undertook some work so that, as far as possible, we were able to make the process similar in all 31 health and social care partnerships. Bearing in mind that a lot of providers work across multiple partnerships, we wanted to develop a process that was familiar in different areas, as far as possible, because there are different circumstances in different local authority and IJB areas.

We have to be mindful of due diligence and our responsibilities for the public pound. We tried to make the process for the release of funding as light touch as we could. We asked providers to inform us of what the funding was for and to give us evidence of their expenditure and use of the funding. My partnership is now releasing increasing amounts of the funding that is due to our providers.

Early on, providers and provider organisations were concerned that the funding was not coming out. They felt that it was unfair that they were being asked to undertake processes of evidence to which we were not subject, but we have also had to justify the additional funding that we are using. The Edinburgh health and social care partnership is certainly releasing the funding now.

Eddie Fraser: Funding and support are coming in a number of ways. NHS support with PPE has been very welcome. Direct delivery through our local PPE hubs has been funded centrally and has gone right out through the whole system. At the same time, it is a matter of trust. We have spent £2 million in buying PPE directly through the council. That was on the basis of trusting that the PPE will eventually feed back through, but we still went ahead and did it.

There are two issues. The first is about trust in relation to going ahead and spending the money when something needs to be done. The second is that there have been other funding mechanisms of supporting the social care sector through the provision of PPE, and that has been very welcome.

Sandra White: For clarification, exactly what process do you go through? The NHS, the IJBs and local groups have been mentioned. What hoops need to be gone through before the funding gets to the people who are asking for it? Time is short, so you might want to give a written answer to let us know. Is the process the same for all IJBs?

The Convener: Perhaps Judith Proctor could briefly indicate whether financial reporting requirements have changed and, if so, whether any of the changes might become permanent.

10:30

Judith Proctor: I am sure that we and our CFO colleagues could provide an update on the process. Providers are asked to complete a form, tell us what the additional funding is for and be able to demonstrate that before we release the funding—that is the process. That, obviously, is additional funding for Covid costs. I am sure that we would be happy to submit that separately for your information.

Sandra White: That would be great.

Finally, as you have mentioned, it is really important that integration authorities work closely with NHS boards. Has that worked well in developing your remobilisation plans? Have you had any problems in that respect?

Vicky Irons: Our experience with the remobilisation plans has, to an extent, mirrored much of the early work with the original mobilisation plans. All that work has been done, essentially, as one system, and I think that the drafts have been submitted to the Scottish Government.

I mentioned fuller strategic needs assessments. Each IJB has undertaken a thorough exercise on remobilisation, which points not only to future service redesign but to the on-going requirements and accountability around the response to the pandemic. As I think Judith Proctor mentioned, the end is still not in sight in relation to that response.

My experience in my system in Tayside is that the relationship and the outcome have been positive. I have mentioned some of the gains, particularly in relation to lots of people practising with a community focus and lots of specialist clinicians now providing care in people's homes in collaboration with general practice. We want to retain all those elements in the remobilisation plans. If anything good is to come from the current situation, those are the aspects that we really want to hold on to.

I know that Eddie Fraser has also had an integrated approach in Ayrshire. I do not know whether he wants to add any comments.

Eddie Fraser: As Vicky Irons said, the approach has been integrated to such an extent that we wrote the community and primary care end of the plans. Jointly with our acute colleagues, we did the unscheduled care part, and my colleague in North Ayrshire who leads on mental health wrote that part of it. We have been fully integrated in putting that together. Indeed, in doing that, we have been looking not only at our immediate responses but at how we act going forwards.

Some of the things that we have learned must be applied to what we do in the future. It has been possible to provide lots of care in the community. One of my general practitioner colleagues said that she was able to do today's work today. By that she meant that she could speak to a patient, phone up a specialist clinician and get advice back, because there was space in the system to do that. That saved long waits for patients.

Real learning can be applied, and we have tried to reflect some of that in the mobilisation plan in order to maintain the good things that we have done. Throughout our reviews, that must be one of our main focuses.

Brian Whittle (South Scotland) (Con): In previous committee work on the integration of IJBs, a repeated theme has been the lack of progress towards the financial empowerment of IJBs. In fact, one of the concerns that the ministerial steering group on health and community care set out is that the focus should be on outcomes and not on which public body put in the pound in the first place. Has progress been made in achieving financial empowerment for IJBs, or do individual partners continue to be influenced by where the money came from in the first instance?

Judith Proctor: I think that we have made real progress in that regard. As you were asking the question, I was thinking about good examples of financial empowerment. The financial empowerment comes at the end of the IJB's role as strategic planner, in setting out its direction and ambitions.

An example—not necessarily a Covid example—is in the work that we have done in Edinburgh in shifting the balance of care so that we can provide more services in the community. The IJB set a direction to deliver a home-first approach in which we focused on supporting people in their homes initially, or, if they were in hospital for a period of treatment, on being able to get them home or into a homely setting as quickly as possible. We were able to reduce our delays and, more importantly, support and care for people in the right place first time.

Through the direction and ambition that were set by the board, we were able to decommission acute care beds in the Western General hospital in Edinburgh, and to use that funding to increase our hospital at home service and our home first capability. That came from the IJB's strategic planning independence, in its role as a public body, and from our role as officers in the health and social partnership, working closely with colleagues in NHS Lothian to make that a reality—to make sure that we had the right pathways in place so that individuals could go home, and that we had the services to respond to that.

The financial capability comes from having a good strategic plan and an agreed direction, and good relationships in working with our partners to deliver that. Ultimately, we have delivered a better outcome. We have enabled better capacity in the acute sector, which can use those beds for other necessary acute services. We have built capacity in the community and, as a result, we have improved outcomes for people and our performance.

Brian Whittle: Quite frankly, I would be interested to know whether other IJBs have any other response or also hold that view. However, I will ask my next question, which relates to the previous one. Do the IJBs consider that they have full control of the resources that are available to them, or does the identity of the partner that provided the funding dictate to some extent whether the money flows back to health or to social care?

Eddie Fraser: [*Inaudible*.]—ability to flex money across the system.

When money comes to us, big parts of the system are quite fixed, so to speak. From my budget, I spend about £15 million a year on care homes and about £20 million on care at home. Large parts of that will roll over, year after year—as will large parts of my health budget, including on community nursing and health visitors.

The ability comes from our doing things a bit differently; we have thereby freed up money and been able to move it around. For example, irrespective of where it came from, we have been

able to move more money to intermediate care and towards the front door of our social care services, which means that we spend less there. Some of that has been health money, which has been used to bring allied health professions across to the front-door services. We have shown real successes at the interface between the health and care services.

Large core services are big parts of the budget that we cannot move—and likely should not move, because they are really good services. However, how we do things differently is the aspect that works really well.

Some elements are more difficult. There is probably no point in saying this, but the system in which we work in NHS Ayrshire and Arran is one in which there is an underlying deficit budget. Therefore, it is hard at times to move money other than where there are clear business cases that show that such a move will cost less, for a better outcome for patients. We continually look at that, and do that work.

Brian Whittle: In looking at the financial data for 2019-2020 in our briefing paper, I have noticed unusual words—there is "an underspend" for East Ayrshire of £2.4 million. Will you comment on that underspend, and on how it might be allocated?

Eddie Fraser: A few years ago, because we had an overspend in our children's services, the council gave us a loan, so we were repaying some of that back to the council. That is within how the integration scheme should work.

We are also investing money in our care-at-home services and intermediate care services. Again, as with the areas that I have already mentioned, that is what we were freed up to do in those areas.

One of the other areas of focus and challenge for us is around our understanding of mental health and addiction, We have therefore created another service around mental health and recovery, and we are focusing on that. It is a real issue for us, and it is one of the issues that we and the IJB work together to focus on. It is about how we take our money and invest it in the areas that we know are challenges for us.

Brian Whittle: In the evidence session on 11 August 2020, issues around Edinburgh health and social care partnership's financial stability were highlighted to the committee. When the Scottish Government responded, it said that it would continue to work closely with the Edinburgh IJB to understand its financial position and provide necessary support. What on-going support is being provided by the Government to achieve financial stability in Edinburgh? How was that financial balance achieved in 2019-20?

Judith Proctor: We did achieve balance last year. We set out a significant savings programme, which we delivered. In fact, we overdelivered on the savings programme that we set out last year, but we had to achieve balance in the year using some reserves and one-offs within the IJB health and social care partnership. That was the first time that the Edinburgh IJB achieved balance in its budget under its own steam with the funding that had been allocated to it. In every previous year, additional funding came from our partners at the year end. Therefore, that was progress.

We are cognisant of the challenges facing our financial position. This year, our opening position was a £23 million gap and, again, we have agreed with the board a savings programme that will address that over the short, medium and longer terms.

The board recognises that true financial sustainability comes not from year-on-year savings plans, but from setting out a strategic change programme and plan that creates a right-size organisation that delivers services sustainably. That is the approach that we are taking with the board and we are in the process of developing that longer-term financial strategy. We go into this year with an agreed budget and savings programme which, when achieved, will again deliver a balanced position towards the end of the year. It will be a significant challenge to do so, but our plans are in place, as is the governance around that.

In relation to the support from the Scottish Government, we have worked with it throughout the Covid crisis and it has supported us through our work with PWC on provider sustainability. We work with a large number of providers in care at home in the city, and we really wanted to work on how best to co-ordinate that and spend our commissioning funding as a partnership, partly to help us to achieve better outcomes for people, and financial sustainability over a large part of our budget, which is the services and packages of care that we purchase for individuals.

That work with the Government has come to an end. We ensure that we are in close contact with the Government on our position, but its financial and practical input came to an end with the end of the work that we did with PWC.

Brian Whittle: Dundee health and social care partnership had an overspend in 2019-20 of £5.3 million. In the upcoming financial year, will the budget balance?

Vicky Irons: We are certainly making progress this year with the financial balance of the IJB and are putting in place lots of plans for developing more sustainable responses across all service areas.

The major pressures in the past year largely involved responding to the demand for social care. Clearly, the additional resources that I mentioned earlier that have been required in response to Covid will exacerbate those pressures, particularly with regard to some of the areas that Eddie Fraser mentioned, such as mental health services, and in relation to some of the key changes that we need to make in the city, such as those around the Dundee drugs commission.

10:45

We are certainly making progress in terms of our financial position and we are working with evidence from lots of other areas with regard to which aspects of service need to go through a level of reform to get us into a more sustainable position.

I joined Dundee health and social care partnership in February—before that, I was the chief officer of Angus health and social care partnership. It is clear to me that the demands in a city environment such as Dundee are very different from those of the area that I previously had accountability for. We need some time to be able to work through the responses and to work through the financial settlement that we need to agree with the local authority and the NHS board in order to respond to the pattern of demand that we are now seeing.

David Torrance (Kirkcaldy) (SNP): Has there been an estimate of the cost of clearing the backlog and returning to pre-Covid levels of activity and performance? What estimates have been included in your plans?

Eddie Fraser: Earlier, I indicated that the Covid situation would cost us an additional £9 million. That is based on our projections for the year in terms of the immediate costs and pressures. Because there have been savings in other places, the net amount is probably around £6 million. However, much of that depends on our model. The public have reacted a bit differently from what we might have anticipated. Some people who were getting some of our lower-level services—our essential preventative services—have been too frightened to use them.

One thing that we need to do is ensure that we take into account not only the health part of what we provide, but the social part. That is essential, and that is where it is useful to work directly with councils. The issue is not only one of funding for IJBs; it is about how that funding flows through to some of our social care in our community services, which have important relationships with people. How do we get our lunch clubs back? How do we get back to a position whereby people engage with each other in those kinds of social settings, which together function as a massive preventative service?

I cannot give you an exact answer to your question, because the answer depends on how we change what we do. Separate from issues around Covid, and within the budget, we could provide a clinical service, but that would not involve the social care services—I know that this committee is also interested in the meaning and the value of the social care services. We need to get an understanding of what we can provide in terms of inclusive and preventative provision.

The cost of things depends on what our ambition is. We are very ambitious with regard to the preventative, social inclusion end of things, so we spend more money on it, which means that people will live healthier lives and will not need so much of the clinical side of care.

Vicky Irons: It is important to make a distinction around the use of the word “backlog”. Most of the activity that is delegated to the authority of the IJBs has continued throughout the pandemic, with a few small exceptions, which I can talk about later. The acute sector has paused some of its elective activity and has a huge backlog in terms of responding to people’s care needs, but we have not done that—we have responded to people’s care needs in a different way.

At the moment, a cause of concern is the additional demands that have been placed on carers, particularly those who were looking after people with complex conditions, who were initially in the shielding category. Some of those people chose to pause their packages of care, to prevent additional people from coming into their home and exposing the members of their family to additional risk. Again, at that point, we did not know what length of time we would be dealing with. We are now in a position where we will have to look at all those needs individually and assess how we can safely start to reprovide some of that level of support. That is already happening.

The other unknown entity is the bubble of post-Covid activity. We are now starting to see a lot of additional demand on our services that is not Covid-related. Some people describe that as deferred activity. People are presenting in the system, who need our care, assessment, treatment and support but have been delaying that for fear of exposing themselves to risk by entering our health and social care systems. Again, we do not yet have a figure on that, but many of the cases that we are now seeing are more complex and therefore will result in an increase in costs. To reiterate Eddie Fraser’s point, each partnership has a figure on what remobilisation will cost, so, if it is of interest, we can provide that level of detail.

The Convener: Thank you. I am sure that that will, indeed, be of interest.

Judith Proctor: I am aware of the time, so I will comment briefly. I endorse my colleague's comments. One of the other elements that we are all aware of and beginning to see is the increase in the burden of poor mental health resulting from Covid lockdown anxiety. That is in the unknown categories of our mobilisation and remobilisation plans; we anticipate those increasing demands on our services.

David Torrance: I have a final question for all the witnesses. On balance, over the whole financial year, do you expect additional costs from Covid-19 to be offset by the reductions in expenditure elsewhere?

The Convener: We heard from Eddie Fraser numbers of £9 million and £6 million. I ask Vicky Irons and Judith Proctor to comment briefly on that question.

Vicky Irons: Again, our additional costs sit at £16 million. I cannot see that being offset by reductions in expenditure elsewhere, because many other parts of the public sector are experiencing loss of income across a range of service areas. Therefore, we are dependent on the additional support from the Scottish Government that was outlined at the beginning of the pandemic to get us through this point. As a collaborative leadership exercise, the public sector needs to understand—beyond the lessons learned reports that have already been commissioned—what it takes to provide a sustainable service post-Covid. To do that, we all need to do an integrated piece of work and a fresh strategic needs assessment, in order to use the resources that we have to the best of our ability.

Judith Proctor: [*Inaudible*.]—would be the same. Our Covid costs for the City of Edinburgh are estimated to be £32 million. That will not be offset by a reduction in activity elsewhere because, as Vicky Irons said, we are also losing income in those areas at the same time.

George Adam (Paisley) (SNP): Good morning to everyone on the panel. I will ask a question that is similar to one that I asked of NHS Ayrshire and Arran last week.

The pandemic and the lockdown that followed it appear to have resulted in a number of innovations in the way that you work. You have already mentioned some of that work. Last week, NHS Ayrshire and Arran said that the pandemic had quickened the pace of innovation.

In addition, we have had some information from Falkirk IJB, which, in reply to the committee's survey, said:

> "it is acknowledged that Covid-19 presents a unique opportunity to accelerate plans to shift the balance of care in light of the available capacity across the health and social care system."

Has that been your IJB's experience? Has the same thing happened with you guys?

Eddie Fraser: It was nice of my colleagues in NHS Ayrshire and Arran to highlight some of the work that we have done. We were very much involved in setting up that interface.

We spoke about time earlier, and our Covid-19 hub was set up within a fortnight. At that time, a number of the GP practices were shut, so we were able to bring in GPs, set up tents for people coming through and really deliver on innovation. The core of that work involved setting up the different communications across the whole system. As I said earlier, we cannot lose that communication.

We have been able see how we can do things differently and ensure that patients get good and early access to services. We need to ensure that we do not lose those things. As we move forward into winter, the redesign of urgent care will be based largely on what we have learned over the past number of months, which includes communication across the system.

If we can divert a sizeable number of people to a place where they can get care quickly, whether they go to the pharmacy or a GP practice first or get advice directly from one of our hubs, we can save people a four-hour wait in an emergency department before they are seen by someone for 10 minutes. It is not about protecting the emergency department, but about ensuring that people get the right care in the right place.

Those are the things that we have learned, and we need to take them forward and ensure that we continue to build on that work. We are currently looking at the process for the redesign of urgent care to enable us to do that across the system.

George Adam: That is interesting. When the representatives of NHS Ayrshire and Arran came to the committee last week, they said—more or less—that the pandemic itself had quickened the process and broken down barriers. My question to them—you might feel the same frustration about this—was why it took a worldwide pandemic to break down those barriers.

Eddie Fraser: I suppose that we all get into the chicken-and-egg situation: who is going to invest first to save later? NHS Ayrshire and Arran has been working across at least seven public bodies—the three councils, the three IJBs and the health board—and we were able to sit down and agree.

It was under my team that we put together the Covid hub and so on. We simply agreed—we put our head of service in there and said, "Do it." We were helped, I have to say, by direction from the Scottish Government, which freed us up to say that we were able to do that. It took that freeing up, if I can call it that—the feeling of joint purpose and necessity—to drive things forward. Again, that was built on a level of trust that funding would come to pay for all of it.

We drove forward, and what we have been able to deliver has been hugely successful. In addition, we have delivered on testing, and we will deliver as we go forward on flu immunisation and—I hope—Covid immunisation. Those things have all been driven together, starting with the core trust that we can do things right across the whole system.

George Adam: My final question is for all the witnesses. Once we move forward and things go back to whatever is the new normal, how will you be able to retain those new and innovative ways of working, keep those relationships going and ensure that you continue to deliver in a manner that is very similar to what Eddie Fraser has described?

Vicky Irons: I hope that everybody has learned the value of that level of collective activity, and learned from seeing the outcomes that are possible when people work together in an integrated way. It is not simply a case of saying "Let's wait and see whether we're able to retain some of that"—it has to be retained.

11:00

Eddie Fraser's reflections on how prepared everybody was to step in and do the right thing have been mirrored across all the communities of Scotland. Somebody used the word "pace" earlier, and I was personally taken aback at just how quickly new arrangements fell into place in Tayside and at just how quickly all the barriers that we had experienced before were no longer barriers. Everybody was prepared to play a part wherever they could.

That extends beyond the health and social care family to our local resilience partners. They helped us—including with practical issues—to put the Covid hubs in place literally over the space of a weekend, within days of the pandemic being confirmed. Surely our collective experience can pave the way for retaining that level of integrated working.

There is one risk with remobilisation and the pressure that will be put on the individual partners that make up the partnership to resume activity that was in place before the pandemic. That may unintentionally encourage some partners to revert to ways of working that were in place before. We put a lot of work into an integrated response, particularly through the local resilience partnerships, so we are mindful of that risk. I hope that we will not go back and recreate some of the barriers that were present.

Judith Proctor: I agree with that. We do not just wait and see; we are intentional about what we are keeping, and we put it in place.

We need to capture and be mindful of the views of people and communities, including on the use of Near Me technology. I have been around health and social care for an awful long time, and for a lot of that time we have been talking about moving to systems such as Near Me and videoconferencing. We made that move in a matter of weeks—the pace of change has been incredible. We need to know and to be able to demonstrate to the people who use the system and who experience delivery of their health and social care services through it that it is as good as services were before—or, indeed, better.

We need to say that we must keep those things. Therefore, let us find ways of investing in them, including shifting our way of working in order to do that. That involves a twin process of learning lessons and examining the evidence to understand that the experience and outcomes for people are as good or better through the new ways of working. We need to be mindful of that.

Emma Harper (South Scotland) (SNP): Good morning. It has been interesting to hear the responses so far. I will pick up on George Adam's interesting question about innovation and the response about Near Me. I am interested in exploring where that fits in with shifting the balance of care and set-aside budgets. I have previously asked questions about set-aside budgets and how we move care from acute settings into the community. We know that the integration authorities are really important in moving care into the community from acute settings.

I am aware that some of the innovative models that have been picked up in Dumfries and Galloway have considered the use of what are called home teams to go out and support people in the community. Do the witnesses think that we can expect changes arising from the pandemic and pandemic planning to result in a complete, long-term shift in the balance of care between hospital and community care? That question is for all the witnesses.

Eddie Fraser: Yes. We have discussed how to maintain things, and clinicians are an important group of people in that regard. If our clinicians, in both acute care and primary care, see that things

can be done differently and better, that helps with buy-in and how we change services.

Part of what we are doing is seeing how we can pull work down into the community from hospitals. One example of that is what we are doing around respiratory care. People can get supported in their locality rather than transferring to acute hospitals.

I think that everyone agrees with the principle of people getting care as close to home as possible. We are now gathering evidence on that—that it can happen—and we need to maintain that situation. Our acute physicians and our GP practices are looking at the question of how people can access GP practices differently. There are now high levels of telephone contact, and people are happy to get that if they get it on the day. Of course, 30 or 40 per cent of people still have to come to see the GP, and that is fine.

We are seeing a real change in what is happening. In my area, we have seen some shifting of money from hospital to the community, but that happened around things that are within the IJB's control, such as the community hospitals. Although we have a long-term programme to deliver change—the caring for Ayrshire programme—it has been difficult to see a shift across to the community of any of the acute budget.

I should say that simply looking at bed nights is a crude measure. What is important is the totality of what goes on in a hospital—out-patients, the ED and a range of other care.

There has been some success, but some of that has been to do with things that are within our control rather than extending across the system.

Judith Proctor: To return to my earlier example, we have had some success with closing or decommissioning services on acute wards. We have closed two wards so far: one at the Western general and one at the Royal infirmary of Edinburgh. We have used the set-aside to invest in community services so that we can support people at home and in a homely setting. That investment has been around allied health professionals who can provide reablement and rehabilitation capacity through community teams.

One of the rapid developments that took place over the Covid period involved something that was already in our plans. We did a couple of test events with the home-first approach, which is very much concerned with how we can support people at home, and the hospital-at-home approach, which can prevent an admission to hospital through wraparound clinical and care services. At the other end, when someone has been in hospital, we look at ways in which we can support them. That involves early conversations, working to a discharge date, rather than working from a delayed date once people are already delayed in the system, and ensuring that we have a flow through from that conversation to robust community services.

As Eddie Fraser said, some of the things that we have been able to do were in our gift because they involve our resources. However, we have worked hard with NHS Lothian to realise a shift in investment—they may be small amounts at this time, but they matter and they signal a possible way ahead. Again, to echo Eddie Fraser's comments, they demonstrate to professionals, clinicians and organisations that it is possible to do that in a way that delivers better outcomes for people and ensures that they can be cared for in their own homes, wherever that is possible.

Vicky Irons: When it comes to large hospital set-aside, even prior to the pandemic, we were starting to see some signs of movement in terms of the level of financial resource that was indicated as part of our financial settlement for this year. However, the issue goes beyond large hospital set-aside. I agree with my colleagues' comments about the fact that the issue is about how we do things and the practices of our front-line practitioners.

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.

Whereas we have previously had robust relationships with a bunch of specialties in the acute sector that are aligned with the IJBs, such as our medicine for the elderly consultants, psychiatrists and respiratory clinicians, we now have a growing number of clinicians providing specialist support—particularly assessment, but also care—in community settings.

We have mentioned Near Me, but that technology is not always required. Many consultants are now providing advice and doing initial assessments by telephone, for instance, and they have adapted to that really well. We need to retain that approach. It would be a real shame if we reverted to a system that was heavily weighted towards and dependent on buildings and infrastructure in order to provide that level of care, particularly given the difference that we have experienced over the past few months, which Eddie Fraser highlighted.

For many people, access has actually improved. It is very different from what they experienced before, but many people can get advice on the day, not only through their general practice but

through a range of other community professionals and, in some cases, right through to specialists, whom people are usually in quite a long queue to see in the acute sector. We really must retain that.

Rather than using all our energy in trying to negotiate a better set-aside deal, we need to bank the credit, if you like, that Eddie Fraser alluded to from the difference that we have seen in clinicians practising in that way, and build on that for the future.

Emma Harper: Thank you for those answers. The committee heard that set-aside budgets were being held or controlled by health boards, whereas they are supposed to be used for other purposes. You have described respiratory and pulmonary care and rehabilitation being done virtually because of the pandemic, and cardiovascular rehabilitation, which we have had issues with, is now also being done more in the community.

I am interested in whether there will be an impact on set-aside budgets and whether we need to consider using them in a completely different way, basically directing the money to community-based support programmes in order to deal with post-Covid symptoms, or what is being called long Covid. Is the set-aside working effectively or does the coronavirus pandemic mean that we need to do something different with it?

Eddie Fraser: Just before Covid, the partnerships were working closely with the Scottish Government on how we use directions. I think that you used that word. How can we and colleagues set things up and say, "We're going to change this, and this will be the impact in terms of strategy, service and finance"? For instance, we have a new pulmonary rehab team and, interestingly, the funding for that came out of the prescribing budget. We were able to do things so differently that we made significant savings. Some of that money went to savings, but the rest went to fund a pulmonary rehab team. That use of deliberate directions from an IJB to both the health board and the council is a way forward.

It is not just about the set-aside budget. That is important, but the set-aside budget is only about 10 per cent of my total budget, and some of that money will always be required for unscheduled care in the hospital, so the amount that could be freed is even smaller.

The important thing about using directions is that we say clearly what we want to change and why, identifying the service implications and, therefore, the financial implications.

The examples that Emma Harper gave are great ones. We think that respiratory care, cardiology and diabetes care can be done more in community settings. We often base the set-aside on bed nights, but much of this will not be about bed nights; it will be about how we look at our out-patient appointments and the range of other interventions that we have. Covid has helped us to show that we can do things differently, and we are working with all our clinicians to make sure that we deliver that.

11:15

Judith Proctor: I agree with Eddie Fraser. The focus should be on what it is that we want to do and what we want to change, and the budget should follow from that. That requires setting out the intentions through our strategic direction as well as through direction from the IJB. I absolutely agree that the focus needs to be on what we are trying to do, not on the budget per se.

Vicky Irons: I would mirror those comments. It is fair to say that the original intent of set-aside has felt a bit clunky—I cannot think of a better way of describing it—over the past five years. It is not the only lever for change that we have.

In addition, it is only a slice of the acute activity that we want to tackle in a different, more integrated way. I am far more interested in having discussions about the total resource; I use the word "resource" rather than "budget", because we see change through people. If we can have an up-front adult conversation about the total resource, where that needs to be and how we can genuinely shift the balance of care into the community, after the experience that we have all just lived through, that is where we need to focus our attention, rather than trying to increase the figure that is nominally indicated in our set-aside budget.

Emma Harper: Vicky Irons talked about refocusing or re-resourcing. There has been a lot of redeployment of people, who have been working from home or have changed their way of working. People who were nominally based in acute care may now be working in a more community-focused way. Have you been able to demonstrate, for example, a saving on bed nights as a result of keeping people out of hospital by supporting them in the community? How adaptable has the workforce been in relation to the relocation or refocusing towards providing services in a community-type way?

Vicky Irons: From my experience, the answer to the question of our adaptability is that we have seen huge efforts from those who have been redeployed, from an NHS background and from a local authority background, in new roles in community settings. Some of those new roles are aligned to the new services that we have needed to put in place.

As colleagues mentioned earlier, we had to set up community testing functions and testing facilities at pace. In Tayside and Dundee, that

began with a very small number of people and grew rapidly to require quite a lot of the workforce to be redeployed and to have the skills to carry out testing in order to keep up with the level of demand.

A whole series of other services, which we would normally expect to be delivered in an in-patient setting, have had to be delivered in an entirely different way, in people's own homes. A lot of the workforce were redeployed to enable them to support that.

It is fair to say that, as we move into the recovery phase, a lot of people are being called back to their substantive posts because they need to be part of the recovery period for the services that have been affected. There is quite a bridge that needs to be formed.

We need to identify which of the new roles that we commissioned and brought into the community we need to keep. New services have formed throughout the pandemic—some of those will feature in the longer term, as they are not simply about an immediate response to demand. We need to understand what those new services are, and we need to have conversations across the agencies to ensure that we retain those skills and those people in those roles. That is quite a significant exercise for us to undertake.

Judith Proctor: We saw extraordinary flexibility and agility from our workforce. We captured some of the views in the lessons learned piece of work that we did in Edinburgh. Based on the responses of those who wrote back to us, many in our workforce valued the ability to be flexible, the different types of work that they were able to undertake and the empowerment that came from that. We need to capture the ability to work flexibly with our workforce—obviously within their terms and conditions and while being fair to them and supporting them and their health and wellbeing. People enjoyed the feeling of flexibility and the empowerment that came from it.

On the question of measuring the difference that was made, through some of the approaches that we took, we saw a reduction in the number of bed nights that were lost to delays of as much as 63 per cent over the period, simply due to our being able to work differently to support people in communities and at home. We absolutely must capture the hard data on the difference that we are making because, if the approach worked during Covid, it will work in winter and in a system that is under pressure. Therefore, we must support people at home—it is the right thing to do. I think that Vicky Irons said earlier that people are keen to experience as much of their care and support as possible in their communities and in their homes. We need to demonstrate the hard data from people's experiences, as well as what our staff are telling us it is possible to do, and do well.

David Stewart (Highlands and Islands) (Lab): Good morning to the panel.

I have a series of questions about delayed discharge. In their report, "Lessons Learned from Reducing Delayed Discharges and Hospital Admissions", the Scottish Government and Health and Social Care Scotland say that the causes of delay are

"compounded by deep rooted behavioural issues",

and that

"Bad became the norm".

Do you agree?

Judith Proctor: "Bad became the norm" is quite a statement. I do not believe that anybody in our system, whichever professional role they are undertaking, comes in to do their job but not to do it well. Everybody is focused on doing what they think is right for individuals.

One of the issues that we see with delays is that we can be little bit too focused on our own lens, and are not thinking through what the individual needs and what they are capable of. It also a case of people knowing what they know. The quote from the report possibly reflects the fact that some partnerships see the decision on where an individual goes post-hospital being made by clinicians and professionals who are not familiar with what we deliver on social care or the capability in the community. I do not know whether you would typify that situation as "bad", or as a reflection of the fact that you cannot know what you do not know and do not have experience of.

Our whole approach to home first is not unique to Edinburgh; they are doing it in Tayside—in Dundee—where Vicky Irons is chief officer. Those are well-developed programmes of work, in which people who know the community, and the capability in it, work with the individual in hospital and pull them from hospital into the community. If my memory serves, that is what the comment in the "Lessons Learned" report means. Those behaviours in and of themselves are not meant to be bad, but they reflect where people stand in the system, what they know and their own professional experience. That is the bit that we need to shift. We need to make it the norm that the people who work in the community with the individual and their family help to decide how the individual is then supported in the community.

David Stewart: Thank you. I will move on to another question. How were additional funds used to reduce delayed discharge in your respective areas?

Vicky Irons: In Dundee, our additional funds were not necessarily targeted at reducing our delayed discharge figures. To reflect Judith Proctor's comments, we were in a good starting position with our ways of working, with the potential exception of funding for some of our more complex care packages. We had a relatively small number of patients in delay at the beginning of the process, and each of the assessments with regard to movement of those patients was done on an individual basis with our multidisciplinary team. We were not required to deploy huge additional resource into that area, with the exception of those with more complex care packages. That was to ensure that we had the resource available to provide every aspect of care that had already been assessed according to the needs of those individuals.

I am not sure whether this is part of the question, but we have used the additional resource in meeting increasing demands for care at home. Those demands have arisen quite naturally. We have also deployed a lot of extra resource into rehabilitation services. That links back to the previous comments about the unknown entity, which is the potential tail of Covid, and the recovery of some people who contracted the virus in the early stages of the pandemic.

Eddie Fraser: We have come from a very strong place in relation to delayed discharges. There has not been a delayed discharge breach in NHS Ayrshire and Arran for many years—the couple of relevant breaches that there have been were outwith the board area. We have an embedded social work team in the hospital, which works very closely with the wards and includes mental health officers, to draw people out.

We anticipated that there might be issues in delivering social care in the community during Covid, so we thought that there might be problems with people who would otherwise have been discharged. To prevent that, we commissioned some extra social care capacity. Our approach was about preventing people from becoming delayed discharges, rather than having to deal with delayed discharges as such.

The discussions about hospital at home and intermediate care models are slightly different things, but in those discussions we talk about how we ensure that that expertise is available in community. On the front page of the "Lessons Learned" report, there is a quote that we use all the time:

> "People talk about delayed discharges but we think about it as a transfer of the care".

People need to be confident that the care of a person has been transferred from a hospital to a different service and that that care is not falling off a cliff. We should be talking about a safe transfer of care. Earlier, we were talking about people's attitudes and why they think that someone must go into a care home when they do not really know what that is. We need to ensure that we can provide confidence that there are good community resources that people can transfer the care to without having to rely on getting into a care home if that is not absolutely necessary—although sometimes it will be.

David Stewart: This is my final question. As the panel know, there was a sharp fall in delayed discharge between February and March, but the Scottish figures are on the rise again. Can we sustain the reduction and could the problem be eliminated altogether?

Vicky Irons: We have witnessed an increase in those numbers in our local partnership over the past fortnight. However, we can sustain our performance in relation to delayed discharges. There may be a link to the journey of the individual prior to admission. I hope that, with all of the additional focus in the community setting, we are reducing the numbers of delayed discharges by also reducing the number of people who need to attend and be admitted to a hospital setting in the first place. We can sustain some of the success that we have had so far.

In response to the bubble that I mentioned earlier—that is not necessarily a good description of what is occurring—over the past few weeks we have been seeing a general increase in demand across the system and people are presenting with symptoms. Unfortunately, those people who may have had a deferred level of illness are now presenting and they are sicker, potentially more frail and with a greater complexity of needs. That will have an impact on our ability to discharge people quickly and into the setting of choice.

We monitor our performance daily across the partnerships in Scotland. As soon as we get an idea of some of the key conditions, we will respond to those and ensure that we make the most of the performance gains that we have seen throughout the pandemic and do not snap back into the pre-Covid characteristics.

11:30

Judith Proctor: We, too, have seen an increase. We had got to historically low levels of delayed discharge in Edinburgh, where we had struggled with it over a number of years. That was down to the mobilisation plan doing things differently. Also, our hospitals were focusing almost entirely on Covid, so we saw a significant change in activity. Those things together affected the delayed discharge position.

As others do, we see our numbers going up, but we want to sustain them at about where they are now. I do not think that we can eliminate delayed discharge in Edinburgh until we do things very differently and at scale. We are working hard to ensure that we have in place processes such as our home-first approach. We have a team that works on that in our acute hospitals and our mental health hospitals for people whose discharge is delayed long term for complex problems.

We also need a sustainable community care service. We have not touched on the fragility of that market, but it will obviously be a subject for the independent review. It is a real issue for us and we do not know what the impact will be post-Covid, as providers come through it and sustainability payments are tapered off.

There are many factors to consider, which makes delayed discharge a complex issue. We are certainly ambitious that we eliminate it because it is the wrong thing for people. People are harmed by being delayed in hospital when they are ready to go home, so we want to be able to get them home as soon as possible. We are keen to do that and are working hard to sustain for Edinburgh the historically low levels, and not to see a return to the high numbers that we had before. However, we cannot eliminate delayed discharge before the significant and large-system sustainable changes that we are trying to make through our strategic plans come.

Eddie Fraser: We, too, intend to sustain our very low levels of delayed discharge, but we can never totally eliminate it. We call it delayed discharge, but I mean anyone who is delayed after the point at which they are able to be discharged, and not just after the two-week cut-off. It sometimes takes time to make arrangements, although we do our best to make them before a person is ready for discharge.

There is also a human rights aspect. When a person chooses where they want to go, how do we make sure that we get them there? We do that quickly, so it is not about going over the two weeks; however, for some people it will take between three and 14 days.

It is about balancing people's rights. We must first ensure that they are not harmed by being left in hospital when they do not need to be there, and we must also consider their wider human rights and ensure that we engage with them and their family about their discharge arrangements. There should not be long delays; they should whenever possible be short, and be about making sure that we get people to the right place with the right care.

The Convener: That concludes our pre-budget scrutiny questions to the witnesses. I thank Judith Proctor, Vicky Irons and Eddie Fraser for their evidence. Vicky Irons mentioned figures relating to remobilisation that might be of interest to the committee; we look forward to receiving those. No doubt there will be one or two other items on which we will come back to you. I thank the witnesses for their attendance and their comprehensive answers.

Subordinate Legislation

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 10) Regulations 2020 (SSI 2020/252)

11:33

The Convener: Agenda item 2 is consideration of a made affirmative instrument. As has been the case in previous weeks, the regulations relate to Coronavirus and international travel. They have been laid under section 94(1), which is on international travel, of the Public Health etc (Scotland) Act 2008.

Because this is a made affirmative instrument, the regulations are already in force, but must be approved by a resolution of Parliament within 28 days of the date on which they were made. It is for the Health and Sport Committee to consider the instruments and to report to Parliament accordingly.

In a moment, we will hear on the regulations from the Cabinet Secretary for Justice. Once we have asked all our questions, we will have the formal debate on the motion, which he will move.

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

I will look to colleagues who might have questions. I draw colleagues' attention to the letter of reply from Humza Yousaf, which we received on 3 September, following a previous appearance before the committee, in which he answered a number of questions.

Two weeks ago, Emma Harper asked questions about ferry travel and passengers arriving in Scotland. Would you like to follow up on those questions?

Emma Harper: Good morning, cabinet secretary. I have a comment on the detailed response regarding ferries, in the letter. I have checked the website of a ferry company that operates between Ireland and Cairnryan, which also has detailed information. I thank the cabinet secretary for his response.

The Convener: Thank you. In relation to that, in his response, the cabinet secretary noted that passenger locator forms are completed by passengers who arrive in Scotland by ferry and, I presume, in ports elsewhere in the United Kingdom for travel onward to Scotland. Can the cabinet secretary also make available to the committee the detailed information from the ferry operators that Emma Harper referred to?

The Cabinet Secretary for Justice (Humza Yousaf): Good morning, convener and committee members. Forgive me for any background noise that you hear; a bit of building work is going on.

Of course, I am more than happy to provide Emma Harper and the committee with the detailed information that we have about passengers arriving via ferry ports in Scotland. If the committee wishes it, we can get that information from Transport Scotland. We have information on entry into ports in Scotland and we can inquire about ports in other parts of the UK. For example, there might be an interest in the ports of Dover and Calais and the number of passengers who travel from there. When people arrive in Scotland, if their passenger locator form says that their destination is Scotland, regardless of the means or method—air or sea—that they chose, they end up in the cohort of data that can, and will, be accessed and sampled by Public Health Scotland.

The Convener: Thank you, cabinet secretary. The instrument that is before us is on the addition of a country to the exemption list. A number of the regulations that you have brought before us have involved adding or removing countries from that list. When we spoke to you a couple of weeks ago, one of the questions that was asked was about how those additions are brought to the attention of Parliament. In your response, you noted that,

"Wherever possible"

you are

"trying to align with the other UK nations",

in relation, for example, to implementation dates and to countries that are on the exemption list.

However, it is fair comment to say that there remains, at least on a short-term basis, misalignment between the countries in the United Kingdom. What on-going work are you doing on achieving a position in which the messages to travellers and the travel industry from the four nations of the UK are, as far as possible, the same message, with regard to quarantine requirements?

Humza Yousaf: That is a fair comment. There is alignment, where possible, but clearly there are areas where there is not alignment.

I saw a good piece by the journalist Peter Smith on ITN about why there should not be too much confusion for travellers. As you know only too well, convener, we have had more than 20 years of devolution, and the reasons why one nation in the

United Kingdom might take one decision while another one takes another are understandable.

An example is the decision to remove Greece from the list of exemptions, which we took last week. I see that other parts of the UK have now removed some of the Greek islands. When we took that decision, it was based on the circumstances in Scotland. You will be aware of the rise in positive cases; the number of cases in that rise that were linked to international travel from Greece gave us concerns, in the Scottish context. It might be the case that there is not that concern in Northern Ireland, Wales or England, so it is completely understandable that one nation in the United Kingdom—in this case Scotland—would take a different position from the others.

I will answer your question more directly, if I may. You will have seen yesterday's announcement by Grant Shapps, who is the UK Secretary of State for Transport. Shortly before he made his statement, he called me to say that the joint biosecurity centre will consider whether it can take a more regional approach to data. I know that the committee has asked me previously whether we can have a more regional approach to data. I have only seen the data for Greece that came in yesterday, but my understanding is that the JBC will provide data on a number of islands, so we can consider the issue on a regional basis. Again, that might help with alignment.

We will try to ensure four-nations alignment as far as possible, although, for understandable reasons, there might be occasions when that alignment is just not possible.

The Convener: In response to our letter, you said that you were continuing to discuss with the UK nations the adoption of a regional approach. Wales has been taking a regional approach for some time and, as you said, the UK Government made an announcement on the matter yesterday. Do you anticipate a similar announcement in relation to Scotland in the near future?

Humza Yousaf: I cannot say, until I have seen the data. Wales took a regional approach last week; it is for the Welsh health minister to explain why that decision was taken. Even if we have data about regional transmission of the virus, we must have real assurance about travel between the mainland of Greece and the islands, because we know that that is where a lot of the danger lies.

I will certainly look at the data. We will seek to take an effective regional approach where we can. However, given the rise in cases in Scotland in the past few weeks, my approach will still be cautious.

The Convener: I have one more question before we move to the next item on the agenda, which is the debate on the motion.

In our previous discussions, and in correspondence, you have said that you were considering the possibility of publishing weekly Public Health Scotland's statistics on people who have recently arrived from abroad and have developed symptoms or have tested positive. Have you come to a conclusion on that?

Humza Yousaf: My conclusion is that we should publish those statistics. We are seeking to find a way to do that that will protect people's privacy. A number of the cases that are linked to international travel involve only one person travelling from a country, so given that there are only a small number of flights to certain countries in any week—sometimes only one—there could be issues about identification of individuals.

Those issues are not insurmountable and we can absolutely work through them. I have already been considering them, but will speed up the process. My instinct and desire is to ensure that the data is published, so we should overcome all obstacles in order to do so.

The Convener: I look forward to hearing more on that in the weeks ahead.

There are no further questions from colleagues, so we move to agenda item 3, which is the formal debate on the affirmative Scottish statutory instrument on which we have just taken evidence.

I remind colleagues that we are no longer in question-and-answer mode, but in formal debate mode. Officials may not participate, at this stage. I invite the cabinet secretary to speak to and move motion S5M-22521 in his name.

Humza Yousaf: I am happy to wait, if anybody wishes to speak to the motion. Colleagues have the detail of it.

I move,

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 10) Regulations 2020 (SSI 2020/252) be approved.

Motion agreed to.

11:46

Meeting continued in private until 12:02.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba