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Health and Sport Committee

Tuesday 29 September 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
25th 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:

Dr Martin Cheyne (NHS 24)
Angiolina Foster (NHS 24)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Richard McCallum (Scottish Government)
Stephanie Phillips (NHS 24)
Dr Laura Ryan (NHS 24)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 29 September 2020

[The Convener opened the meeting at 09:30]

Scrutiny of NHS Boards (NHS 24)

The Convener (Lewis Macdonald): Good morning, and welcome to the 25th meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton.

We have a busy agenda today. The first agenda item is an evidence session with NHS 24, as part of the committee's on-going scrutiny of national health service boards and special boards.

I welcome to the committee from NHS 24 Dr Martin Cheyne, who is the chair; Angiolina Foster, who is the chief executive; Stephanie Phillips, who is the director of service delivery; and Dr Laura Ryan, who is the medical director. I wish a good morning to you all.

We will ask questions in a prearranged order, because that works best in a virtual meeting of this kind. I will start with the first set of questions, after which I will ask each committee member in turn to ask their questions and invite witnesses to respond. I will generally invite one witness to respond. If others wish to offer additional responses, they should indicate that by typing "R" in the chat box.

I will start by considering the position of NHS 24 in relation to the NHS generally. Clearly, NHS 24 is a national service that deals with a broad range of health conditions. I guess that it deals with pretty much every other part of the NHS in one way or another.

Do witnesses agree with the proposition that NHS 24 sits in a position that is useful for surveillance of the rest of the NHS? If so, in what ways is that true, and to what extent is the position utilised? How does the organisation feed intelligence or views to the rest of the NHS ? We will start with Dr Martin Cheyne.

Dr Martin Cheyne (NHS 24): Good morning, convener. I thank you for the invitation to attend this morning's meeting. NHS 24 does, indeed, have a very unique position and role to play in the wider system of the NHS. We are very data rich, in that we serve the population of Scotland. We have a collection of data that is used by Public Health Scotland to enable it to analyse and inform health services and service delivery.

Although we are unique—indeed, we have become more unique in the past six to nine months because of the data that we have collected during the Covid pandemic—we certainly have information that has enabled the NHS and Scottish Government officials to analyse and inform forward planning.

The Convener: Does Angiolina Foster want to add anything on the interrelationship between the intelligence that NHS 24 provides and the direction or advice that it receives from elsewhere in the NHS to make best use of that?

Angiolina Foster (NHS 24): Absolutely. One of the things that characterises NHS 24 is the range of channels through which we deliver our services, which we do principally through telephone and a number of digital sources. As my chair, Dr Cheyne, explained, that means that we are very data rich, because so much of our interaction with our callers and patients is recorded in one way or another.

I will quickly give two examples of the services. Our 111 service is a strong example of our telephony-based services, and NHS Inform is a strong example of our digital services. Both those services are being used to feed intelligence to other parts of the wider system, exactly as you have suggested, convener. I will give a couple of examples of that.

For wholly understandable reasons, much of the focus in the public narrative around the pandemic is on the requirement for intensive care capacity. However, because NHS 24's service comes much earlier in a patient's journey, our data acts as a lead indicator. For example, for the purposes of predicting a second or third wave, our service-demand patterns will begin to show demand some weeks ahead of an intensive care unit peak. That is a volume indicator.

Equally important is that we can, at geographic level, use the data from our call patterns. We share that with Public Health Scotland, among others, to help public health colleagues to anticipate and predict very localised outbreaks.

Those are just two examples. The committee might want to hear more detail on that from Laura Ryan, our medical director, who leads on engagement with public health professionals, and would, I am sure, be happy to expand on that.

Dr Laura Ryan (NHS 24): As Angiolina Foster has outlined, we have worked very closely with Public Health Scotland over the course of the Covid pandemic. Prior to that, NHS 24 intelligence and data went into the unscheduled care data mart, so data sharing is not something new to us. We use it for live service monitoring and planning, and strategic planning. An example is mental health services provision. We noticed over the

course of the pandemic that mental health services provision had quite rightly been expanded; our intelligence made clear the demand for our mental health services.

On our data on equality and diversity, we became aware that we had to make information, guidance and our 111 service accessible. As we have done that, we have developed dashboards of data that allow us to monitor and report on that intelligence. That digital information, as well as information from our 111 service, is shared with Public Health Scotland to ensure full and in-the-round gathering of data and sharing of intelligence, with a narrative.

David Stewart (Highlands and Islands) (Lab): Good morning. I have several questions on evaluation of your service. What should the public expect from NHS 24?

Angiolina Foster: The public should expect a wholly accessible, clear, reliable and trustworthy clinically assured service. Evaluation clearly underpins your area of interest; we evaluate our services on several levels. Structured evaluation is an inbuilt part of our service development process, which I will illustrate with an example.

In March 2019, we launched a new mental health service and after six months of operation there was a structured evaluation. More often than not, evaluation is, for reasons of objectivity, carried out by an external party, as you might expect. The subsequent expansion of that service would not have happened had the evaluation and feedback not demonstrated the strong appreciation, value and so on of our service. Evaluation is inbuilt and is very structured.

Evaluation also works at a more organic level, which is every bit as important. That involves our day-to-day interactions with our public, our patients and our partners in the delivery pathway, and it happens live. We listen to many evaluations extremely carefully and we aggregate them in order to hear what the thematic messages might be.

There is another important part of our evaluation work. Because we deliver through a number of channels, the same service can be available to the public through different routes. We very carefully analyse the effectiveness and the value to the public of the different routes.

A specific example is our Breathing Space service, which is a compassionate listening and advice service for people who are experiencing low mood and anxiety. That is available through the telephone and on web chat. My colleague Stephanie Phillips, who is our director of service delivery, might wish to expand a little on that, if the example is of interest to the committee. We see different demographics coming through the two channels, and we see different levels of need coming through them. Through evaluation of the channels, we are learning an important point about potentially more accessible routes for delivery of the service for certain sub-groups in the population. That is a level of nuancing that we are working on almost constantly.

I will pause to see whether that has been of help, and whether the committee would like my colleague to expand on the web chat versus telephone evaluation.

David Stewart: Thank you for that. It was very helpful.

You have touched on my next question, but perhaps you can give a few more examples. Are you basically saying that external evaluation helps your organisation to learn and improves it? Is that a fair summary of your comments?

Angiolina Foster: Absolutely. That is a perfect summary. We have a small team in the organisation that is engaged in quality improvement work, and we have a patient-experience team that draws proactively and responsively on feedback from our users. All that feeds into our thinking on improvement.

David Stewart: I want to move on to other questions about evaluation, and to take you back to the early days of NHS 24. As you are aware, there was some criticism then about delays in answering calls and staffing problems. Have those issues been fully resolved?

Angiolina Foster: The very high-level answer is yes. I point out that the difficulties preceded the tenure of colleagues who are at committee this morning, but we are aware of that background. My understanding is that the difficulties related to the setting up of what was, at the time, a radical new service model. All those issues have been addressed.

A core challenge for all contact centre based organisations is what is described in our language as the “call arrival patterns”. It is clear that there are peaks and troughs. Members of the public will find that, if they call at a time when the service is under less pressure, they will often wait merely a matter of seconds to get through to us, but if they call in a period of extremely high demand, they might have to wait a few minutes. We try to manage that in real time with the recording that callers hear. With the 111 service, callers hear a message that gives an indication of how long they might have to wait, and they can make their own decision on whether to call back at a less busy time. We try to empower the caller to make their own judgment and we try to help them to have the best experience.

09:45

David Stewart: This is my final question. What assessment have you made of the benefits of NHS 24 to the rest of health and social care services? Is the average patient—obviously, that is a difficult concept to quantify—aware of the architecture of the NHS? Are they aware of when they should telephone the general practitioner, and when to go to an accident and emergency department?

You will be aware that, in England, the problem arose from a minority of people who were using A and E disproportionately. I know that there have been studies on that. Do you face a similar issue in NHS 24?

Angiolina Foster: That is such a good question. You have put your finger on a real issue for us. It is a big and, arguably, unfair ask of the public to work out exactly the most appropriate access routes across the entire health and care system. First, the onus should be on the various providers, including NHS 24, to make access routes as clear and simple as possible.

Secondly, it is for us, as a system, to make the quality of public communication and explanation as good as possible, rather than expecting the public to navigate an inherently complex set of choices. Therefore, a key role for NHS 24 is to guide people through the system.

NHS Inform is used by many citizens to work out where best to access services. That is a key role that we play. I ask the committee to appreciate that, in normal times, services are in development, so it might well be that the correct access route for the public changes as services are brought on stream. That has been even more the case during the pandemic.

I illustrate that by saying that, before the pandemic, 90 per cent of NHS 24's 111 case load came to us in out-of-hours periods, which is as the system was designed. As was alluded to in the question, GPs are the principal port of call for citizens in in-hours periods. I point out that out-of-hours periods account for 71 per cent of the week—a big chunk of the week.

On 23 March, and in direct response to the pandemic, NHS 24 has also been the front door for Covid-specific assessment both in hours and out of hours. That has been done in order to give the public an unmissably clear and accessible route into Covid clinical assessment. It was also—this alludes to the first part of the question—a way taking pressure off the wider primary care system by drawing Covid clinical assessment towards a national service.

The other thing, in a similar vein, that NHS 24 has done in response to the pandemic is the setting up of a non-clinical helpline—an 0800 number that is available nationally from 8 o'clock in the morning until 10 pm, seven days a week. It is not 24/7, but the opening hours are long. It deals with general inquiries about Covid.

I am conscious that I have not yet picked up on the detail of the question on evaluation of the benefits to the service. I am happy to do so, but I am conscious that I have spoken at length. I will therefore pause to check that my comments have been helpful, and then I can pick up on the question about how we measure the benefits to the wider system.

David Stewart: Thank you. That was a very full answer. I am conscious of time, and other members wish to come in, so perhaps you could drop a line to the committee.

Angiolina Foster: I will do so.

David Torrance (Kirkcaldy) (SNP): My question is around performance targets and relates to your answers to David Stewart's questions.

NHS 24 provided the committee with a summary of performance against its targets. It shows that NHS 24 is meeting most of its targets, but the area of poorest performance relates to the time taken to answer calls. Will you expand on the reasons underpinning the missed targets?

Angiolina Foster: I will start the answer, but the committee might find it helpful to hear from my director of service delivery, Stephanie Phillips.

I reassure the committee that all our clinical targets are not only met, but exceeded, which is an important patient safety observation. You are absolutely right that the targets that we have missed relate to the time taken to answer calls. There is an important patient priority that sits underneath that, which allows me to refer back to the earlier discussion about evaluation.

We talk to our user groups all the time about what is important to them in our services. A little over a year ago—possibly 18 months ago—we did an important piece of research with our callers. We asked them, "What is more important to you: to have the phone answered extremely rapidly—in seconds—or, once you get through, to be dealt with in one single transaction?" Please bear with me while I explain that, regardless of high levels of demand, in order to answer the phone in seconds, which can be done, the service requires to quickly deal with the immediately presenting need and put the patient in a queue for a call back. That was the key feature of the previous operational model—there was a rapid response, and the patient was put in a queue for a prioritised call back.

The strong message from our public engagement was that the unequivocal preference

of our patients is to be dealt with without the need for a call back. In our dialogue with them, we explained the trade-off between speed of answering and not requiring a call back, and they clearly said that they would rather wait a little longer for access to the service in order to be dealt with in one transaction. That is an important underpinning factor. For that reason, we and the sponsor department in the Government are reviewing the target in order to identify a target that better reflects what I have just explained.

Stephanie Phillips (NHS 24): I will pick up on the points that Angiolina Foster has made. We recognise that the average time taken to answer calls is a key measure. However, in recent months, the challenge for us has been the sharp increase in call volumes, which has a direct impact on our capacity requirements as an organisation. As Angiolina said, that was driven by a discernible shift as we took on the role of the national access route into the Covid pathway. We saw a shift from predominantly out-of-hours provision to increased in-hours activity, and we had to shift our workforce and capacity to accommodate that. That is another factor that is part of the consideration.

As Angiolina Foster said, we manage the process in real time. We make use of up-front messaging, which means that, when a call is answered, callers are advised how long they might wait. We also encourage people to take decisions at that point, such as whether they could access information through NHS Inform. Callers might choose to access that route first.

We try to keep the public and callers informed at all times when they come into the service, but clearly that remains a challenge. As we have moved towards the new model and tried to focus on the overall patient journey time, one important thing that we have seen is a significant reduction in the total time for which people engage with NHS 24. We are putting minimal numbers of people in a queue, and we now manage the calls in a single transaction more than 90 per cent of the time, which is a significant shift from where we were previously.

David Torrance: The data shows that, between 8 and 9 per cent of calls are abandoned altogether. What happens to abandoned calls? Can you call those people back?

Stephanie Phillips: One thing to say up front is that the abandonment rate is not always reflective of a bad thing. As I said, the first message that someone hears when they phone NHS 24 is that, if they have a life-threatening emergency, they should put the phone down and dial 999. We encourage people to go to the emergency services if that is appropriate. It is important to point out that we are not an emergency service.

As I said, when callers come in during the in-hours period, they hear a message that encourages them to think about contacting their GP, if that is a more appropriate route. We also try to route people to NHS Inform. It is about choices that people make at the start of a call.

The abandonment rate is directly linked to levels of demand. I do not want to get too technical, but there is a correlation between those things. Clearly, at times of acute system pressure when callers are waiting longer to get in, they might choose to abandon. However, we monitor the volumes of people who try again and we can track and analyse that information. We can be assured that there is a degree of safety, because we know when people have attempted to recall. We cannot call them back, because we do not have a connection with them and we do not have a number to call them back on, but we can track whether someone has attempted to come back into the service.

We monitor the abandonment rate, as that is a fairly standard measure of contact centre performance, but we are cognisant of the fact that it is not always a bad thing if somebody has abandoned, because they might have made the right choice rather than hanging on for us to answer.

George Adam (Paisley) (SNP): I want to ask about staffing. NHS 24's most recent annual review said that staff attendance was at 92.6 per cent as opposed to a target of 95 per cent. That is in your annual report, but in paperwork that you have provided to the committee, we see that, in some quarters since 2019, the figure has fallen below the target again. For example, in quarter 2 of 2020, it was 93.1 per cent. Can you explain what that is all about?

Angiolina Foster: I say up front that our attendance levels are not as good as they need to be, and that the issue is a key priority for the board and our executive management colleagues. There are a couple of historical systemic or structural issues, which I suggest Stephanie Phillips explains to you.

I will give a more up-to-date sense of what we are doing at the moment. We have a very detailed action plan, which has been constructed in collaboration with our staff side, because it is clear that our staff side needs to work well with management on such an issue. Our partnership colleagues on the staff side are wholly supportive of the actions that we are taking. We invited a critique of the attendance management action plan by our internal auditors to put a bit of stretch into it, and they gave us some very helpful comments. Therefore, we have further strengthened the plan.

10:00

We have also taken very seriously the fact that attendance management is not all about the human resources rule book; it is also very much a staff wellbeing and support issue. A contact centre environment can be very pressured, so we need to be very supportive of our staff, as well as firm where that is appropriate.

There are two things that we have changed in the past year or so in order to address the structural issues that we believe contributed to that situation. With the convener's permission, I suggest that Stephanie Phillips explain those two things to the committee, because they are pretty fundamental to our work. At the moment, things are getting better in the area—they are moving in the right direction—and we have set a further 2 per cent improvement target.

Stephanie Phillips: It is important for me to reflect that, obviously, one of the biggest challenges for us is that we work primarily on a shift basis, and a lot of the shifts that our staff work are the less favourable ones—out-of-hours, evening and weekend shifts. That is a factor without a doubt. From listening to staff, we gained an understanding of the fact that shift working and the shift arrangements that we had in place were quite a driver of absenteeism.

A contact centre can be quite an isolating environment. People go in and plug in, and that is their day. We recognised that we needed to create a sense of teamworking—to really think about how we could bring staff together to work in discernible and identifiable teams. The shift review that we undertook last year, which took us 18 months to do and involved 900 staff, and was therefore quite a significant undertaking, was geared towards aligning staff more closely with one another. We aligned them not only with the team that they would work in but with their manager, and created time for interaction with and support from their manager and their peers.

There was a real desire and intent to create a learning and working together culture and discernible teams in the organisation through that review. That included building in protected time at the start of shifts and within rota patterns for development, learning, sharing and general wellbeing. We have expressly built that into the patterns that we have in place.

George Adam: My question is for the chief executive. If we take on board all the challenges that you have said you face, and accept the figures that you are struggling with, how do you propose to deal with the added pressure? You are going through a major recruitment drive to prepare for a potential second wave of Covid-19. How are you dealing with that, knowing the challenges that you already face plus the extra challenge? Where are staff being recruited from?

Angiolina Foster: Two main staff groups are relevant to that question—our call-handling staff and our nurses. The answer is quite different for the two groups.

We have found it extremely easy to recruit call-handling staff successfully for the expansion to the numbers that we need. The sad truth is that that is a reflection of the deeply difficult labour market facing the population. Large numbers of skilled people with first-class customer care skills are without jobs at the moment. People have been casualties of some of the economic impact of the pandemic, and we have been the beneficiaries of that. In the expansion of call handling, our challenge has been less around recruitment and more about the logistics and time pressure involved in training those staff at the rate of knots that is required.

Our recruitment of nurses has also been relatively successful so far, but that is a pressure point across the entire health and care system, as I am sure the committee is aware. We have to work harder to find our nurses. In recent months, however, where appropriate we have been very successful in borrowing nurses from other health boards—nurses who have found themselves stood down in certain areas of service. There has been good sharing of that key clinical capability across the system.

In the past few months, we have also brought other clinical disciplines into the organisation as we have developed the service in response to the different needs of the pandemic. There has been good permeability between different health boards to move our scarce clinical colleagues to exactly where they are best placed.

George Adam: I have two final questions on the points that you raise. How long does it take to train staff and what will happen to them in the mid to long term when the pandemic subsides, and how many redeployed staff has your organisation benefited from during the pandemic?

Angiolina Foster: I will take the question on what will happen first. The answer depends on which area of our service staff have been recruited to work in. We anticipate that the expansion will be permanent in some areas—for example, the expansion of our mental health hub to a 24/7 service, which is the example that I mentioned earlier in relation to the role of evaluation. We anticipate that the population's need for that service will not diminish in the foreseeable future and that those staff are therefore likely to be with us post-pandemic.

However, a number of the staff who have been recruited for the increase in call-handling capacity,

for example, are on temporary contracts and they wholly understand that. What happens to them will very much depend on where the service model and pressures land at whatever point we decide that the country is emerging from any final wave of the pandemic. It is not possible to say with any certainty or reliability exactly what proportion of staff we will keep and for what proportion we will need to end their temporary contracts.

The point on how long it takes to train is different depending on which bit of the service staff join—my colleague Stephanie Phillips could give you some detail on the matter—but the training is intensive and of quality.

I personally do not have the number of redeployed staff at my fingertips, but I am happy to follow up with a note to the committee so that I do not guess that number but give you a wholly accurate figure.

The Convener: That would be helpful. Thank you.

Stephanie Phillips: I want to differentiate up front between what normally happens and what has been happening throughout the pandemic, during which we have brought in a considerable number of additional staff into the organisation. Normally, we have a four-week training programme, which is a mix of two weeks of classroom training and two weeks of supported working in what we call protected pods, in which staff work on the floor and deal with live calls under enhanced supervision. That programme reflects the need for call handlers and clinicians to be able to deal with, and manage, anything that comes into the 111 service.

During Covid, we operate one single clinical pathway—the national pathway—so we have brought in additional capacity to provide it, and condensed the training period to reflect that need. We now train people in one week, during which we teach them how to use our system, because the additional staff are not required to deal with anything other than that one pathway and they are supported to do that.

Emma Harper (South Scotland) (SNP): I have a couple of questions on digital exclusion or, more positively, digital inclusion. The submission from NHS 24 said that there are a number of ways in which existing services are being enabled online and mentions the growing role of the provision of digital services.

A number of examples have been provided: translators from NHS Greater Glasgow and Clyde and NHS Lothian are being brought in to help translate Covid public health information; the NHS Inform website has expanded its availability of translated material; and NHS 24 worked with the community to create a glossary of terms to be used for translation, taking account of local dialect and nuances in language.

Are there particular groups of people at risk of exclusion from any of those digital services? What can be and is being done to engage people who might be excluded, such as black, Asian and minority ethnic people, Gypsy Travellers and others who might not necessarily have digital access?

Angiolina Foster: We have a small but passionate and energetic team in our organisation whose core focus is participation and equalities. That key group engages with members of the public across all those groups at risk of a range of sources of exclusion, of which digital exclusion is one, and actively and constructively engages with the many representatives of that wide range of interest groups and potentially excluded people.

In the digital context specifically, our online NHS Inform content is, at today's date, available in 11 minority languages, many of which pick up the BAME grouping to which your question referred. In addition to those 11 minority languages are British Sign Language, easy read and audio files, which reflect our engagement in addressing exclusion through disability as well as potential exclusion through race and language. The team that I referred to also actively engages with the Gypsy Traveller community and its representative groups, so that community is also within our range.

10:15

Although we work hard on inclusion and on closing down any risk of digital exclusion, it is not the job of my organisation to attempt to fix the root causes of digital exclusion single-handedly. There is a national issue with connectivity. The most recent programme for government included a clear commitment to address infrastructure at a national level.

Digital access can address other forms of inequality. For some individuals, travel to a clinical site for a consultation might pose financial hardship due to the cost of travel. For someone with a disability, taking public transport to a clinical site can be a major issue. For those people, the offer of a digital route is welcome and can provide access to advice that they might otherwise not have been able to secure for themselves.

Another, more subtle area is that there can be forms of emotional and psychological exclusion. For some areas of need, particularly in mental health, some people feel unable or disinclined to articulate their issues face to face or even by telephone. However, when they are offered a digital channel, that provides an access route through which they can reach out for the help and

support that they need. Digital channels offer an interesting mixture of risk and opportunity.

Dr Ryan: In addition to what Angiolina Foster just outlined, it is also worth describing the benefits that come for everyone when we recognise potential digital exclusion and respond to and provide for that, particularly during Covid.

Telephony is always an option for the public. We recognise that 85 per cent of callers phone us on a mobile, but the option to call us from a land line remains. That option continued during Covid, even though huge numbers of those who accessed our services did so through nhsinform.scot.

I will highlight two other examples. Digital development benefits all patients. We can now prescribe remotely and share the record with community pharmacies. No matter who you are or how you access 111, your prescription can be sent by clinical email, with clinical detail that the caller has shared. That ensures maximised safe prescribing and the best patient experience.

We have also identified groups of people who did not have any digital access or who could not use the technology for some reason. Because NHS 24 is positioned at the very start of the patient journey, we recognised that those people needed appropriate access to signposting for testing. We collaborated with our partners to make arrangements for that group of people who could not access signposting for testing via digital means. We speedily passed those people on to our partners so that their needs could be responded to and so that they would not be delayed in the system, either digitally or through the telephony routes that are normally used.

Emma Harper: I have another wee question about the public's involvement in designing the services. I am wondering how the public are engaged. The NHS 24 submission states:

> "NHS 24 had the opportunity to accelerate the GP Web Services programme to increase the availability of GP Practice websites to enable their local populations to access local information".

Do you have any information on how many GP practices participated in that programme, with NHS 24 supporting them to widen their website provision to include education, for instance?

Angiolina Foster: I will start by picking up on the question of how the public are involved, and Dr Ryan can pick up on the point about GP websites.

On the question of how the public are involved, NHS 24 has adopted the Scottish approach to service design, which is a four-stage process. The first stage is called discovery, which is a little bit of jargon that refers to talking to our customers. That is an in-built part of how we would start any process for either creating a service from scratch or redesigning an existing service. We would sit down with our user groups and the public and make a point of engaging not only with people who use our services but—importantly—with those who do not. We believe that, in a service design moment, it is just as important that we listen to the people who, for some reason, are not yet accessing our services.

One example of where good-quality engagement with the public has really improved a service is NHS Inform. In 2016, the service was refreshed, with intensive public input. Before the refresh, the number of visits to the NHS Inform site was between roughly 30,000 and 40,000 a month. After the refresh, over the following months—right up until Covid, to give you a more representative level of usage—the monthly usage was routinely hitting 4 million visits. With good user input, everything—design, accessibility and value—is improved.

Perhaps Dr Ryan can come in on the point about GP websites.

Dr Ryan: The gp.scot resource was developed to enable us to collaborate with the British Medical Association and GP colleagues to ensure that the front-facing element of primary care and general practice, which the public recognise as their front door to urgent care, gives people access and choice via channels to access primary care. As we know, that supports the GP's role as the expert medical generalist, as well as supporting the multidisciplinary team and the provision of information in that regard.

As Angiolina Foster described, our design is user centred, engaging not only with citizens and patient groups but, critically, with our partners and the people who deliver that care to patients. Patients want to know that their clinicians and the supporting teams have been involved in designing a service for them.

To go back to the original question, the initial plan was to implement the initiative in 30 practices but, during Covid, we have been able to scale that up to 60 practices. That specifically allows for alignment and visibility so that the end user—the patient, or anyone who is using the practice on the patient's behalf—can immediately access all the NHS Inform resources. The platform also enables the NHS Near Me service, which offers the ability to consult remotely with patients. As we know, when that approach is chosen by patients, it is a very effective means of interacting clinically with them.

Ultimately, it comes down to the realistic medicine approach and what is important to the patient. We are expanding channel choice and meeting the demand for digital access while

retaining the benefits of face-to-face contact for those who need it.

Emma Harper: I have a couple of questions about Covid-19. Angiolina, you described the evaluation of the NHS 24 service. Have you seen an increase in activity at the Covid community hubs recently, and might that indicate that there is a second wave?

Angiolina Foster: As we have gone through this pandemic, we have seen different patterns come through, both in our part of the patient journey and in the Covid hubs. At the moment, there is not, to my knowledge, a peak coming through the Covid hubs. However, as I tried to explain, as a lead indicator, an increase in activity in our bit of the service might begin to show.

Perhaps Dr Ryan would like to expand on that, as she is our key interface with that part of the service.

Dr Ryan: As Angiolina described, we have seen demand increase at different times during this pandemic. Initially—quite understandably—when there was a public appetite for information and a certain amount of worry, there were high volumes of calls. Because of the nature of those calls, we were able to give a lot of self-care advice. That, in turn, meant that only sicker patients were referred to the Covid hubs. We self-cared an average of 25 per cent of callers during the initial wave, but at times of increased demand 50 per cent received self-care.

Another recent peak in activity came when children returned to school. There was a similar pattern to before, with an increased number of calls. That was probably because of the attention and focus on children going back to school. Again, we received very high volumes of calls, but a very high number of people received self-care.

During the pandemic, we have monitored both unscheduled care and Covid outcomes. We have done so for safety reasons and because of the impact on our partners—we realise that Covid hubs and community assessment centres are staffed by a very precious resource. Nonetheless, we need to balance that impact with the risk to patients.

In the early phases, we had an initial requirement for our partners to call patients with a less urgent need back within four hours. However, as time went by that number began to decline and the figure for the one hour outcome began to increase again. It is worth noting that we recorded all the data about patients who were deemed to be "at risk": those in the shielding group and the flu vaccination group.

We are working with our partners to establish the current demand and impact on Covid hubs. I will probably need to get back to you with our report on that. However, one of the groups that we hear from at this time of the year is people who are post-vaccination. That has the potential to make Covid hubs very busy, but taking an evidence-based approach and working with partner experts has meant that we have been able to come up with a pragmatic approach to that group that means that we are supporting traffic to the Covid hub.

Emma Harper: It is interesting that you have seen an increase in traffic due to flu vaccinations, for example. We will have a massive need for more people to have flu vaccines.

Are you seeing any trends, such as a drop—or, conversely, an increase—in calls regarding particular conditions aside from Covid? For instance, are you having more calls related to mental health conditions? Obviously you will be monitoring trends in increases or decreases in calls about particular conditions.

10:30

Dr Ryan: As I discussed earlier, we have aligned our Covid pathway to public health data, to allow the patient's journey to be visualised from beginning to end. That allows a continuous stream of data on the group who, due to a range of conditions, would normally get the flu vaccine, and the shielding group. We have been able to monitor throughput on that.

Five per cent of the people who call us have chronic obstructive pulmonary disease. As we know, that is a group that we need to be careful about, given their respiratory risk.

In answer to your question about normal volumes of callers, I would say that, as well as Covid pathway monitoring, we have consistently been monitoring our unscheduled care loads. That would be the people who phone for reasons other than Covid during out-of-hours periods. Constant monitoring of that has demonstrated that we have not seen any change in call patterns. For instance, we have not seen people presenting with conditions later. The profile of call reasons has pretty much remained exactly the same, and we expect that to continue. Obviously, we will monitor it in relation to winter illnesses.

We have the data. We have flagged the Covid records and we will keep an eye out for particular conditions. That intelligence is extracted hourly to the Public Health Scotland database.

Emma Harper: We are hearing about more and more people describing symptoms that are labelled as "long Covid". Are those patients calling NHS 24 or looking for information on NHS Inform, or are they going to their GP?

Dr Ryan: Long Covid is a very hot topic—I suppose that is one way of putting it. My understanding is that those patients access services through their GP. It is an area where patients have an understanding of appropriate access and who best to speak to, which would normally be their GP.

Our approach to clinical triage is to assess each person according to their needs, on a person-centred basis. If, through our clinical triage, it was recognised that someone potentially had symptoms that were persistent but did not require referral at that time, they would be directed to their primary care physician, who knows them best and has their medical records.

Sandra White (Glasgow Kelvin) (SNP): Good morning, panel. Thank you very much for your submissions.

I want to follow on from Emma Harper's questions. You will know that the Government is monitoring four areas of harm from Covid-19, two of which are direct health impacts and indirect health impacts. In your answers to Emma Harper, you talked about Covid symptoms. I am more interested in people being directed to dental services, GP services and so on, because of lockdown.

I know that Emma Harper touched on this. Has NHS 24 seen an indirect health impact of Covid-19 and lockdown in that regard? If you have, where is it most noticeable? Emma mentioned mental health. Has there been any other negative impact on people's health when you have had to direct them elsewhere?

Angiolina Foster: Yes, that is the case principally in mental health. As the committee may expect, there are much higher levels of anxiety in the population. The root cause is a mixture of economic worries due to furlough or job loss and family and relationship stresses and strains that are, if not triggered by lockdown, certainly exacerbated by it. I am very sorry to say that there is a higher level than usual of people with suicidal thoughts—that is a discernible and alarming trend. The short comment on that is that a range of internal wellbeing issues are coming through starkly in our work.

You are right to mention dental services. A key part of our service is the Scottish emergency dental service, which runs as part of our out-of-hours service. It is one of the options available through our 111 service. Because of the standing down of community dentistry for safety reasons, we rapidly changed our working model and we benefited from some dentists who could not work in the community working for NHS 24 on a pro bono basis, and with no public thanks. This is a good opportunity for me to give them credit and thank them. That allowed us to offer an enhanced service through our digital and telephony routes with the additional workforce there, and that has been a good model. Because that has been so well received by the public and clinicians, we are now running that to evaluate it as a possible longer-term service change.

I think that Dr Ryan would like to contribute on the wider Covid harms point.

Dr Ryan: I will build on Angiolina Foster's point about the dental service and an earlier point that I made about expanding our service in response to user feedback. Working with our partners in the community, we have expanded prescribing in the dental group. Not only did patients get that extra level of triage, but—although dentists were not able to work for safety reasons in the community—we made the patient experience and journey quicker through the system in general, because dentists were able to prescribe through NHS 24.

The other benefit was that dental staff were able to directly refer to advanced services in our hospital system—for instance, to maxillofacial services. The addition of dental staff expanded our advanced clinical support team in NHS 24, advanced prescribing and improved the patient journey.

Sandra White: You talked about dental services. Emma Harper mentioned patients with COPD. Has there been an increase in more severely ill patients presenting to the service with Covid-19?

Dr Ryan: Sandra White caveated her question with reference to Covid-19. Through our data and intelligence, we monitored that daily and, as I said before, shared it with national data pools so that the patient journey could be monitored all the way through. NHS 24 understood from the very outset, working with the Scottish Ambulance Service, that we needed to manage resource appropriately and get the safest outcome for patients. Over the course of the Covid pandemic, we have seen a gentle increase—but nonetheless an increase—related to Covid time trends as people got sicker. That aligns with the increase in one-hour referrals in the Covid hubs and, although we had a very high four-hour referral figure initially in the Covid hubs, as the pandemic progressed, probably within three to four weeks of the first wave, we began to see a trend of more unwell people. All that data goes to Public Health Scotland. Part of that was about measuring at-risk groups—people who have chronic disease or disorders who would normally get the flu vaccine or those extremely at-risk groups that were shielding. All that data was being monitored.

Sandra White: Thank you. I have one more question. I do not know how you might want to

answer this, but do you think that the restrictions that we have in relation to lockdown and Covid-19 are striking the right balance between minimising direct health impacts and indirect health impacts? That might be an unfair question.

Angiolina Foster: I have to say that I am tempted to dodge it, if I may, given its complexities and its policy nature. I think that that is not a question for us to have a view on, if that does not sound too defeatist on my part.

Sandra White: It is very honest. Thank you; those are all my questions.

The Convener: I would like to put a variant of that question to Martin Cheyne. Does the board of NHS 24 feel that its role in dealing with direct and impact impacts is properly reflected in the tasks that it is being asked to undertake?

Dr Cheyne: NHS 24 has worked very closely with Scottish Government colleagues to try to ensure that we respond to the demands of the service that we have seen. This is a rapidly changing situation, and the board's governance mechanisms over the period have been slightly enhanced to ensure that we are responsive and fleet of foot, so that we are able to respond to the changing situation.

There have been lessons to be learned as we have gone through this. We are all aware of the redesign of urgent care programme that is coming forward, which we as an organisation are participating in actively. We see clear benefits from that.

There will be a time to review the lessons learned from all of this—although that time might not be now, we will have to do that. We have done some work on lessons learned on the governance side; we have been part of a national group, through which all health boards have been reporting to Scottish Government colleagues on national lessons that have been learned so far, and that will continue.

My answer to the committee is that it is an evolving situation. We are receiving all the support and help that we have been asking for, from Scottish Government colleagues, health boards, territorial boards and other national boards. We are very grateful for that.

Donald Cameron (Highlands and Islands) (Con): My questions are about mental health. The panel has helpfully addressed some of the issues in answers to the questions that were just asked. You have provided a striking graph, which shows a fourfold increase in mental health calls since the onset of lockdown, and you have covered what those have involved. How, as a service, has NHS 24 adapted to address that very steep increase in demand?

Angiolina Foster: I will start, but I might suggest that my colleagues follow on.

As a point of clarification, we run mental health services that are clinical and services that are less clinical, in the formal sense of that term. The mental health hub that we have mentioned, which has gone from operating four nights a week to operating 24/7 over a relatively short period of time, runs on a psychosocial model. In other words, the approach recognises that, often, people are not clinically unwell; their issues might be, at root cause, loneliness, isolation and so on. Our response has been to develop a skill set in the organisation that is designed around the more psychosocial model—our colleagues are called psychological wellbeing practitioners.

In other areas, there is a rather more clinical focus. There is a resourcing issue in both instances—I am looking to my colleagues, particularly our director of service delivery, Steph Phillips, who might like to contribute.

10:45

Stephanie Phillips: Thank you. It is fair to say that there has been quite an expansion in our offering in the area. As Angiolina Foster said, the hub has gone from being available four evenings a week to being a 24/7 operation. Some of the increase in demand reflects that additional availability, but undoubtedly there is a clear and evident need to access the service in and out of hours, so we will look to maintain it—without a shadow of a doubt.

We have been heavily involved with a number of partners in the evolution of our mental health services over the past couple of years, and particularly in response to Covid. In June this year, we became a level 1 responder as part of the distress brief intervention programme that is being rolled out nationally—there is a commitment in the programme for government to sustain DBIs. We get about 300 referrals a month through that system, which means that we can link to and help people to access services locally, in their communities.

We have been doing collaborative work with Police Scotland over the past few months. That work has come to fruition and enables callers who access the 101 service to be routed to our mental health hub. Often, a police officer turning up at someone's front door is the last thing that is required in such a situation, so we have worked closely with Police Scotland to develop a pathway whereby our hub is able to take the call. More than 65 per cent of those calls are not being referred anywhere else in the system, so we are managing that demand very successfully within our mental health hub.

Again, we get about 300 calls a month in Scotland through that system, so we can see that it brings strong benefits across the wider system beyond health—I am thinking about the resources that Police Scotland requires in dealing with such activity. We are keeping people out of emergency departments, too, when those are not the appropriate places for them.

Donald Cameron: Thank you. I am grateful to Stephanie Phillips for addressing not just the non-Covid element of what has been happening over the past few years but interagency working, which I think that we all accept is very important.

Is your approach working? Are we seeing a drop in attendance at accident and emergency departments? You touched on that.

Stephanie Phillips: We get roughly 2,000 calls a week to the mental health hub, and fewer than 10 per cent of those result in a 999 call or an emergency department outcome.

The challenge for us now is to understand whether that is new activity or a change in existing activity coming into the 111 service. As part of our work with Police Scotland, we will evaluate the approach and its benefits in terms of police attendance and transfers to the ED. We are confident that we are reducing the requirement for other bits of our system to deal with such calls, because our staff can deal with them in a more appropriate way.

I should add that we are endeavouring to put in place a similar pathway with the Scottish Ambulance Service. Then we will really start to join up the response in a more appropriate way. I believe that that will result in a reduction in attendance at the ED from all three agencies.

David Stewart: I have one final question, on dental services. Sandra White has covered most of the questions that I wanted to raise.

I appreciate that you will have a partial view of this issue and that dentists themselves will have a more direct view. However, what barriers are there to the resumption of full NHS dental services, with safeguards such as appropriate equipment?

Angiolina Foster: I am sorry, but I do not feel sufficiently informed to give you a useful answer to that question. I am not sure that any of us is. I think that we all feel that that is a little bit beyond us, and we do not want to waffle.

David Stewart: Okay; thank you.

The Convener: You have given us a good insight into the dental side of your operations already; that is much appreciated.

Brian Whittle (South Scotland) (Con): Good morning. We have been looking very much at the issues that the pandemic has raised with regard to putting the NHS on an emergency footing, as it were, which resulted in quite a few services having to be paused, for obvious reasons. As Sandra White alluded to, there is a concern that the Covid restrictions might have led to indirect harm and might have resulted in unmet need in relation to people presenting with other health conditions.

Which services do you think should be at the forefront of remobilisation, and which are under most pressure to restart?

Angiolina Foster: If the question relates to NHS 24 services, you must allow me to start with a point of clarification. Like other health boards, we use the phrase “remobilisation”—we are part of that corporate family, so we adopt the language—but it is a bit of a misnomer with reference to NHS 24 and the pandemic.

As you are aware, our territorial board colleagues had to stand down large swathes of plans, elective procedures and so on, but that was not the case with NHS 24. To the contrary, we were standing up additional quantities of pre-existing services and establishing completely new pathways and services. Therefore, the concept of remobilisation is a little bit misleading, and that will slightly colour my response to your question.

In response to Covid, we did four main bundles of things. We set up the new national pathway for Covid; we stood up the non-clinical helpline, which is the 0800 number that I mentioned; we significantly expanded all our mental health services; and we rapidly developed and expanded all our digital services.

With regard to your question about our priorities, at the moment, and until global and United Kingdom circumstances change, my answer must be that all four of those areas remain core service priorities for NHS 24.

Brian Whittle: I will look at the issue from another direction. You will be on the front line of calls coming in about medical issues, so you might be able to shed some light on which patients are most at risk, what conditions they have and which are getting worse.

We are trying to put a picture together of the services that have been stood down and the conditions that patients have. We have heard a lot about chronic pain; chest, heart and stroke; heart conditions; and cancer treatment and referrals. You also mentioned mental health. Which conditions most concern you?

Angiolina Foster: I will start our response, but I suggest that our medical director is best placed to give a fully informed response.

We know that there is a top 10 for the conditions that tend to account for the majority of our patients’ needs. Dr Ryan will want to say a little bit

more and perhaps tease out for you what those 10 conditions are, but at this stage my strong sense is that they remain a stable package of top 10 conditions.

Dr Ryan: As Angiolina Foster said, we closely monitor all our outcomes on a daily and, indeed, hourly basis. The top 10 conditions can vary seasonally. In general, they follow that seasonal pattern, as well as abdominal pain, headaches, fever in children and respiratory conditions. From my description, you can see that some of them overlap with Covid. Nonetheless, there is a reasonable public understanding that, in the context of Covid, there are three very specific symptom groups.

Because of the monitoring, we are also able to look at 999 end-points, which might be a good indicator of severity of illness and the presentation of life-threatening conditions such as heart attack or stroke. I can confirm that we have not seen any increase in the number of 999 calls for ambulances for those conditions; the figure remains consistent at 6 per cent. Nor have we seen a clinical analysis in NHS 24 or any feedback that would reflect the fact that people were not presenting with those life-threatening conditions. Nonetheless, I should go back to the point that when people call NHS 24, those two conditions are highlighted at the beginning of our initial voice directions, and at that stage, people might choose to self-refer to an emergency service.

To answer your question, therefore, there are no obvious safety issues around presentation of life-threatening illnesses, and no evidence thus far in relation to the cases that you mentioned, such as chronic pain.

Brian Whittle: I am slightly surprised, I have to say. Is the data analysis set up to monitor that? For example, we are aware that the reduction in the number of chronic pain clinics is causing specific issues; we are also aware of similar issues with other conditions. Is the data analysis set up to give us that in-depth analysis?

Angiolina Foster: If I may, convener, I would like Dr Ryan to respond to that.

Dr Ryan: We have what we call keywords in NHS 24, and the keyword comes from what the patient tells us is their main concern or issue when they call. “Pain” is one of those keywords. To again go back to a previous point, if someone needs pain to be dealt with urgently, they will be referred either to the usual out-of-hours routes or, if they call during the day, they will be redirected to their general practitioner. Therefore, there is a person-centred approach. Chronic pain would be part of our clinical assessment but it would be covered under the umbrella of the “pain” keyword.

The Convener: Finally, I come to finance. I note that your submission mentions the extra costs as result of Covid. Has the Scottish Government committed additional financial support to NHS 24 in the current financial year and, if so, how much?

11:00

Angiolina Foster: Our year-to-date figures for Covid-related costs are just a little more than £3 million, and we are projecting a little under £10 million by the end of the full year. I need to caveat that heavily by saying that those are based on current service demand patterns and so forth. At the moment, trying to predict even a month ahead feels a little long term. Those numbers may well change as the pandemic progresses. As you would expect, we are in constant dialogue with the Government about those costs. In turn, the Government properly challenges those costs and ensures that we are driving them down as much as we can and offsetting with anything that we may can through an internal financial offset. That all goes without saying.

We have not yet had a formal allocation letter, but we have had indications from the Government that those costs appear to be robust; therefore, we are running our budget this year in the expectation of receiving those funds, which we require for Covid-specific purposes.

The Convener: Will that allow you to balance the books in the usual way?

Angiolina Foster: Indeed.

If I may, I would like to take the opportunity to clarify a point. It may well have caught the committee’s eye that NHS 24 is in receipt of brokerage. I would like to clarify that although we are in receipt of brokerage it is not for the normal reason of there being an underlying financial deficit—NHS 24 is in balance, in both the short term and the medium term. The brokerage was atypical and was to allow a more value-for-money purchase, several years ago, of a major new information technology platform for the organisation. It would have cost the public purse more to have paid that up year-on-year and therefore, in agreement with the Government, a better deal was achieved. However, for that reason, a brokerage lump sum of £20 million or so was given to the organisation. We are on track to pay that back and we have kept all those payments going in a stable way, as planned. The year after next there will no longer be any brokerage. My main point is that there is no underlying financial deficit, which might otherwise be the assumption when one sees that there is brokerage.

The Convener: Thank you for that clear explanation. We look forward to receiving

additional information in those areas that you have indicated. I thank all the witnesses for their helpful responses and for outlining the work of NHS 24 over time and in the current circumstances. No doubt we will hear from you further in due course.

Pre-Budget Scrutiny 2021-22

11:03

The Convener: We move on to the second item on our agenda, which is pre-budget scrutiny evidence. This follows our general approach, which as members will recall, was a process recommended by the budget process review group. We have heard from several organisations on budget matters over the last couple of months and, as with our evidence session with NHS 24, much of our other work informs us on budgetary matters.

Last week, we heard from the Minister for Public Health, Sport and Wellbeing, Joe FitzPatrick, who answered a range of questions. This week we will hear from the Cabinet Secretary for Health and Sport. I welcome Jeane Freeman to the committee, along with Richard McCallum, who is interim director of health finance and governance at the Scottish Government.

As before, we will take questions in a pre-arranged order. We will seek to fill in any gaps from our previous evidence and I look forward to the responses. I invite the cabinet secretary to make an opening statement, which I am looking forward to hearing.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, convener, for your flexibility in accommodating my attendance. As members know, last week's events and announcements required reprioritisation of time. I thank Joe FitzPatrick for attending last week's meeting and answering the committee's questions, in my place.

Before I go further, I give my sincerest thanks to all our NHS and social care staff for the considerable amount of work that they have done, and continue to do, to meet the challenge of the pandemic.

In recent years, we have tried to put our health services on the strongest possible footing, but we need to go further in order to embed a world-class public health system, and we need to sharpen our focus on population health. The pandemic has demonstrated the positive changes that we can make to how and where we deliver healthcare, which we must lock in. By accelerating the transition to a new model of community NHS care, and supporting digitisation of services through facilities such as NHS Near Me, we can ensure that people receive the right care, in the right place and at the right time.

I turn to funding for our health and social care services. While the pandemic has had a massive human cost, it has also come with significant

financial implications for our front-line services. It is essential that we have funding in place to meet additional Covid costs. The Government has acted quickly to put in place the necessary infrastructure to support rapid decision making and approval of spend, which is balanced by due governance of public spending.

We agreed to provide initial funding of up to £100 million to ensure sustainability of social care services, and I made it clear to the committee that we would provide the necessary funding across health and social care following the conclusion of our detailed quarter 1 review of expenditure. Now that that review has concluded, I have confirmed this morning to Parliament and the convener that we are making available £1.1 billion for NHS boards and integration authorities. That will provide boards and integration authorities with funding for additional Covid expenditure that has been incurred, and with funding that is necessary for the coming months, including support for remobilisation, social care, our NHS test and protect programme, personal protective equipment and hospital staffing levels. My officials have worked closely with NHS boards, integration authorities and the Convention of Scottish Local Authorities to review the financial implications and to develop the most appropriate funding approach for our health and social care services.

In making the funding available, I will make clear two important points. First, I recognise that Covid costs have had significantly disproportionate impacts on some areas. Our funding takes account of the disproportionate impacts, although we also recognise the need to distribute resource equitably and transparently. I acknowledge that some boards and integration authorities will require support beyond the level that has been confirmed today. I will consider all such requests carefully and will expect them to be properly evidenced.

Secondly, in making today's funding announcement, I confirm that we will undertake a further substantive funding allocation in January. That will provide the opportunity for us to understand better the implications of Covid across the sector for the remainder of the financial year, and it will ensure that our front-line services continue to have the funding that they require.

On pre-budget scrutiny for 2021-22, it is essential—as, I am sure, the committee will agree—that our health and social care services have the funding certainty that they need for this and future years. As my colleague Kate Forbes made clear last week, achievement of that is being made additionally difficult by the unacceptable position of the Scottish Government and other devolved Administrations in again facing a delayed UK budget. The Scottish budget envelope is tied to the UK block grant and is set by the UK budget and tax policy, so a delayed UK budget creates huge uncertainties for the Scottish budget and our NHS and social care. It is impossible to plan with certainty without that information.

I can assure you, convener, that I will continue to do everything that I can to support our front-line services, to ensure that the necessary funding is provided throughout the pandemic, and to support delivery of a world-class public health system. We have announced £1.1 billion of funding today and have committed to a further substantial funding allocation in January. I hope that the UK Government quickly changes its position, so that in January we can provide our NHS and integration authorities with the certainty that they need for next year and beyond.

All that being said, convener, I am happy to take any questions that you or committee members might have. If I may, I will call on my colleague Richard McCallum for any detail that I might not have immediately to hand.

The Convener: Thank you, cabinet secretary. That is much appreciated.

I will start with questions on where you finished—the budget for this year and next. You mentioned the delay in the UK budget, but I expect that commitments that you have made on passing on consequentials will remain in place. However, beyond the consequentials of which you are aware and are able to budget for, have you taken any policy decisions on additional funding that might be required in order to maintain the level of services that you have assessed as being essential? If so, what estimate have you made of any potential gap between Barnett consequentials and current and future need?

Jeane Freeman: As, I think, Mr Fitzpatrick explained to the committee last week, we remain in a fluid situation in terms of anticipated demand. For example, we are modelling demand for personal protective equipment for the coming months through to the end of this financial year on the basis of demand in March, April and May. That implies, correctly, that we will continue, through all the channels that we have developed, to supply PPE to our acute settings, primary and social care, and unpaid carers. We will use the distribution routes and channels to pharmacy and so on.

We can model anticipated demand from the Covid pandemic for worst-case and best-case scenarios, and we can calculate spend based on what we have already spent and the £1.1 billion that we have allocated. However, it is more difficult to understand—and to continue to model and remodel—how the behaviour of the pandemic might impact the level of services remobilisation that we require and wish to see. As I said in a

statement to Parliament not too long ago, in thinking about how we remobilise the NHS and what the cost of that might be, we need to understand the pressures on the NHS from Covid in terms of admissions to hospital and intensive care units; the impact on primary care and the demand on the NHS from test and protect; and the important flu vaccination programme this year, which is intended to reach a larger number of people than in previous years, through our having added to the cohorts who are eligible.

That is a constant planning exercise in which we reflect on and discuss matters with our boards and the integration authorities. I will speak to some integration authority chief executives later this morning with my colleague Councillor Currie from the Convention of Scottish Local Authorities. That constant planning exercise is determined largely by how far we can move forward with resilience in the system. It is also based on how virus outbreaks play out, our capacity to contain them, and our overall intent in suppressing the virus to prevent community transmission. That might mean that, from time to time, we need to increase further the resource that we put into test and protect beyond what we had originally planned.

11:15

The Convener: I am interested to know whether there is any more certainty around another question that was asked last week. The question was about resources moving from areas where there has been lower health provision activity in the course of 2020 to areas where there is and will be higher need. Is it possible to quantify the shift in spend from areas of lower activity to areas of higher activity?

Jeane Freeman: We have been able to do some work on that. Richard McCallum will give you whatever detail we can provide at this time—bearing it in mind that it is not by any means final.

Richard McCallum (Scottish Government): There are two elements. One is about the immediate term; there might be some short-term offsetting savings for health boards. As a result of Covid, boards might not have been able to provide some services as planned, so they will not have incurred some variable costs that would have been associated with those services. As part of the review that we have undertaken with health boards, one of the key things that we are considering is where those offsetting savings are. The committee would expect that, as part of the robust financial governance that we are undertaking.

The second strand concerns the longer-term approach and where shifts might be in the future. We have already started to see a shift in the balance of spend. In some ways, it is too early to say—I know that it is unhelpful to say that, at this stage—but as we go through the next few months and see some more investment being made in the community, we will be in better position to assess how much of that shift has happened, both in the short term and in the medium to long term.

The Convener: Thank you. Emma—[*Inaudible*.]

Emma Harper: I did not catch what you said there, convener, because there was a loss of signal, but I am assuming that you are asking for my question now.

The Convener: I am indeed.

Emma Harper: Good morning, cabinet secretary. I have a couple of questions about Barnett consequentials. The Scottish Government has indicated that £500 million is to be allocated to health boards in respect of the first quarter of 2020-21. Is that in line with the amounts that are set out in the mobilisation and remobilisation plans that have been submitted by boards, or will some boards receive less than their estimated spend?

Jeane Freeman: The £1.1 billion is distributed to boards largely on the basis of the NHS Scotland resource allocation committee formula, under what Joe FitzPatrick described last week as a hybrid approach. We recognise that some boards—rightly and appropriately—will have incurred higher costs than the NRAC formula would necessarily refund them for. That refers not only to the costs incurred, but to future planned costs.

In working with boards and health and social care partnerships individually, we aim to ensure that boards that have incurred additional costs, beyond what they would receive through the formula, get additional funding, provided that that is properly evidenced, that we have the iterative process of challenge and scrutiny that Mr McCallum and I have described, and that we reach an agreed position with the boards concerned.

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

Jeane Freeman: At this point, the Barnett consequentials are £2.5 billion. As I have said, we have allocated £1.1 billion this month as a result of the quarter 1 review and our looking ahead to what we anticipate boards' cost will be. As I have also said, we will look at the situation again next January. Whether the Barnett consequentials will be sufficient to meet all the additional expenditure is almost an impossible question to answer at this stage. Other parts of Government will have their own views about the impact on their portfolios.

I do not know whether additional consequentials will come. That, in part, will depend on the continuing discussions that we are having with the UK Government and the Treasury on, for example, social care. However, we have been able to use the funding as I have described, and we have been able to hold back some funding that we believe will be needed in January, so that boards can allocate some of the Barnett consequentials to planning for, and being sure that we are prepared for, a second wave, and so that they can use it for other areas, including for PPE, in respect of which we are not clear about the exact final amounts.

Every penny of the Barnett consequentials will be used for health and social care. Whether those pennies will add up to all that we need to spend is not entirely clear. The committee will recall that we gave a clear commitment to the Convention of Scottish Local Authorities to resource social care as needed to meet the Covid challenge. For example, we have introduced the social care staff support fund, we have taken steps on death-in-service benefits for health and social care workers, and we have covered indemnity requirements across those areas. We have taken a number of additional measures that will incur costs, but we have done so because we believe that those were the right things to do.

Emma Harper: You have described the situation as being "fluid". It is obviously a real challenge each day to project and plan any financial processes. An additional issue is that the Westminster Government does not have a budget, or is not proposing to have a budget, that you could work with. I am sure that that is really challenging.

We took evidence on appropriate additional costs. Can you give examples of what those could be? You have already described the additional social care funding.

Jeane Freeman: Appropriate additional costs can range from the cost of PPE to cost of additional staffing. Additional staffing might be required, for example, to allow a service to be delivered, or to accommodate reduced productivity because of the additional level of PPE that staff have to wear, which results in the normal volume of patients that they might otherwise see being reduced. In those cases, we want to increase the number of clinics so that the same volume of patients can still be seen.

Appropriate costs may also include the capital cost of reconfiguring parts of the estate to ensure that we maintain the Covid pathway and Covid-free pathways. That includes establishment of the hubs and the assessment centres, and additional funding for NHS 24 to take on, as it has done so well, the significant additional request that it continue to provide levels of services that cannot be provided face to face. That is particularly applicable to how we have scaled up NHS inform and to how we have used digital to provide a significant range of mental health support to various parts of the community.

Appropriate additional costs cover a range of items that health or social care services might require in order to continue to deliver the best possible services in the face of the on-going pandemic.

Emma Harper: What methodology or formula is being used to allocate the initial tranche of funding for quarter 1 of 2020-21? Earlier, you described an NRAC-hybrid approach, which Joe FitzPatrick also described last week. Will that methodology be used for 2020-21 and for future allocations?

Jeane Freeman: The hybrid model is in place in recognition of the fact that the impact of the pandemic has differed for different boards. Some boards have been disproportionately more impacted in responding to the pandemic than others. The NRAC formula exists and is agreed. It provides a degree of equity of allocation so it is the foundation. However, as I said, where boards can evidence that they have additional costs beyond what they will receive through the NRAC formula we will go through the proper process of scrutiny and challenge, led by Mr McCallum, and when we reach a settled position those boards will receive additional funding, over and above the NRAC formula.

The Convener: For clarity, cabinet secretary, the impression that the committee formed from last week's evidence was that there would be a consistent methodology to address the issue, but the way that you have described it as deciding what is required beyond NRAC sounds like a case-by-case approach. Is that correct?

Jeane Freeman: Yes, it is, because it recognises that different boards have been impacted in different ways. That inevitably places a greater burden of work on Mr McCallum and his colleagues, but it seemed to us to be the fairest way to address any individual board's case. The NRAC formula, in and of itself, was insufficient to properly reimburse boards or allow them to plan for the additional costs that Covid was bringing in their direction. We have taken that approach for these figures and I expect that we will take that approach again in January.

The Convener: Thank you.

Donald Cameron: I am grateful for the clarity about new Covid spending that has been announced today. It is welcome, especially as the Minister for Public Health, Sport and Wellbeing was unable to answer my questions on it last week. I have to say that, given that the committee has been undertaking pre-budget scrutiny for

months and has only just been presented with these new figures, during the meeting, I find the cabinet secretary's criticisms about not obtaining financial information from the UK Government somewhat ironic.

How have decisions been made on how much to allocate to social care? Were the sums based on an analysis of need or on the Barnett consequentials received in relation to social care?

Jeane Freeman: I have two things to say. I am sure that Mr McCallum will be able to add some of the detail on how we have worked with COSLA and the integration joint board chief finance officers, but let me say for the record that undertaking proper due scrutiny, challenge and coverage of individual board returns and reaching the position that we have reached and which has been conveyed today is not in any respect, to any reasonable person, comparable with the UK Government refusing to determine and allocate a UK budget in the appropriate time, which shows utter disrespect for the devolved Administrations. The two are not comparable. I am sure that Mr Cameron and I will have that argument elsewhere on another day.

11:30

Mr FitzPatrick could not have given the committee that figure last week; if I had been here last week, I could not have given you the figure either. That is no slight on Mr Fitzpatrick or on me; it is a reflection of the thorough way in which, with our boards, we have taken a proper look at the expenditure that was incurred in quarter 1 and at how the forward plan would take us into the early part of the next calendar year.

Regarding social care, on 20 March we made the commitment, to which I have referred, to support reasonable funding requirements and any additional expenditure that is fully aligned to local mobilisation plans. In other words, we said that we would support any additional expenditure incurred that was above the increase in the Scottish budget and that was caused by social care services and IJBs responding to Covid.

We have worked with the IJB chief officers and with our colleagues in COSLA. We must remember that the funding and delivery of social care is a joint exercise between the Scottish Government and COSLA. From memory, I think that we have already committed £100 million in additional funding. We continue to work through that with the IJBs, because, in some instances, they have not yet given us the evidence of their additional spending. I will ask Mr McCallum to take us through the detail of how we have gone about that.

The Convener: Can we have Richard McCallum?

We might have to come to Mr McCallum in due course—

Richard McCallum: I have come in now. I can add two points to what the cabinet secretary said.

I will deal first with the approach that we have taken to the social care funding that has been incurred so far. The allocation that has been committed today includes all the funding that IJBs have estimated for social care for the first quarter. We have worked closely with chief finance officers from the integration authorities, who understand the costs that they have incurred in the first quarter. The allocation is based on that actual spend.

For the forecasts for the remainder of the year, we have agreed with the integration authorities that at this stage we will provide 50 per cent of their assumed future costs for social care, with a view to reviewing that in November, once they have received more detail from providers in the voluntary and private sectors. It has taken integration authorities some time to work through all that detail with their providers. That is why we think that doing a further review in November will allow us to be clear about the full costs for the year.

That is the approach that we have taken so far. About £150 million has been allocated for social care as part of today's commitment.

Donald Cameron: What arrangements do you have in place for internal scrutiny of additional social care spending? Is it the same for health and for social care, or is there a different approach?

Jeane Freeman: I am not entirely clear what Mr Cameron is referring to. Do you mean internal government scrutiny?

Donald Cameron: The autumn budget revision states that a total of £220 million was transferred from the health budget to local government in respect of what might be called social care. I am interested in how that is internally scrutinised, regarding governance, what has and has not been spent and so on.

Jeane Freeman: That work is led by Mr McCallum and is then signed off by me. I am sure that he will be happy to take you through the detail of how he goes about that.

Richard McCallum: I will make a couple of points. First, the £220 million to which Mr Cameron referred was agreed as part of the budget settlement for the current financial year, 2020-21. That funding is passed to integration authorities to support the delivery of social care, so it is slightly different from the money that we

are talking about today in relation to the Covid response.

With regard to how we go about scrutinising the delivery of outcomes against that funding, we take two main approaches. First, one of the benefits of integration is that we now have a pool of chief officers and chief finance officers with whom, as a Government, we have close relationships, and so we have an opportunity, through one-to-one sessions and by meeting with them as a group, to scrutinise the progress that has been made on spend.

Secondly, as I said, the £220 million was part of the budget settlement, and it was anticipated that a range of outcomes would be delivered against that funding. We take forward our approach to funding for social care through scrutiny against those outcomes, as we do for other parts of the system.

A key point, to which the cabinet secretary alluded, is that, alongside integration authorities, we work closely with the Convention of Scottish Local Authorities on those matters, recognising that there is a partnership between health and local government.

Donald Cameron: My final question is about how future sums that might be directed towards social care will be agreed. Will that funding be in line with the amounts that are identified in the mobilisation and remobilisation plans?

Jeane Freeman: There will be two areas of future funding for social care. The first will be a continuation of what is in the current Scottish budget. Additional funding for Covid expenditure will follow the same process that we have adopted up to now, and will be set against the local mobilisation plans.

Finally, I repeat the point that Richard McCallum made. It is important to understand that the Scottish Government's relationship with the NHS is different from its relationship with the integration authorities. Every NHS board produces an annual operating plan that sets a series of outcomes, financial requirements and areas of spend. We agree those very detailed plans with the boards, whose performance is assessed against them at the end of each year.

With integration authorities, the approach is different, as there is a partnership approach with COSLA. The same degree of detail is not there, but outcomes are the focus of the work that we undertake with the integration authorities.

George Adam: Good morning, cabinet secretary. Donald Cameron is quite correct—for the past couple of months, we have been diligently going through the budget process here. Aside from Donald Cameron throwing the toys out of the pram a couple of minutes ago, I would like some clarity. We have spent some time going through this process, cabinet secretary, and you have spent time dealing with a worldwide pandemic on your doorstep.

Is it not the case that any disrespect that has been shown to us here has been shown by the Westminster Government, which has not set a budget? Is it not the case, considering all the pressures that we are currently under, that the Westminster Government has, by postponing its budget, been totally disrespectful to the devolved Governments?

Jeane Freeman: I certainly hope that I or my ministers and officials have shown no disrespect to the committee, because that is the last thing that we wish to do. It has been, and is, disrespectful of the UK Government, not only not to have a budget at the normal time but not to have the courtesy to advise our Cabinet Secretary for Finance of that change in its position, such that I think that she found out through social media, or perhaps through mainstream media coverage.

That situation does not help us to work co-operatively as Governments of the nations of the United Kingdom, far less as equal partners in that endeavour. It makes it exceptionally difficult for us to know how we will plan our spend and what degree of stability and security we can give to our NHS and—from my portfolio perspective—to our adult social care, for the years to come.

A great many people are anxious about what will happen in 2021-22 and beyond. It is frustrating—to say the least—not to be able to engage with the UK Government in meaningful conversations at this point. We are—currently at least—irretrievably tied to the UK budget envelope and we do not know in what way it will impact on our planning and resources.

George Adam: I move on to some of the questions that I asked last week about community hubs, which Joe Fitzpatrick adequately answered. We are all aware that the summer budget revision identified spending of £35 million on community hubs, which were established to provide a front-line community response to people affected by Covid-19. The aim was that hub services would facilitate face-to-face scheduled appointments for individuals who needed further clinical assistance.

Community hubs have been found to provide different ways of working. How much of that new way of working will be retained, post-pandemic or generally in the future?

Jeane Freeman: It is a good question. We intend to retain the approach that the community hubs and assessment centres quickly developed and established. At the moment, we hold them ready to stand, should we see a significant

increase in the number of cases—just now, we are managing major outbreaks but they are contained outbreaks. We need to have the hubs ready to respond—as we do our NHS—to any increase in Covid cases, such as happened in the period from March to early summer.

We are also considering how to make use of the infrastructure of the community hubs and assessment centres, to help us to redesign unscheduled care and ensure that people receive the right care in the right place. A and E is not the right place for many of the individuals who currently attend it, so we have to be able to provide those people with a more local place that is right for their needs and care. We can do that through community pharmacy, and the establishment of the pharmacy first service was a major step forward.

Together with our clinical leads and those who are involved in both acute and emergency department care and primary and community care, we are actively considering how to use the community hubs and assessment centres infrastructure to help to redesign urgent care.

George Adam: Part of that redesign of primary care and how we deal with patients as they go through the process is about the impact of community hubs on GPs' workloads. Has there been an impact? Has the approach helped GPs' workloads? In the future, could we use the hubs as a different way of working, instead of everybody automatically thinking that they have to go to their GP? The point is similar to your point about A and E: a lot of the time, A and E is not the first place to which people should go; likewise, a GP's office might not be the first place to go.

11:45

Jeane Freeman: It is a good point. The hubs and assessment centres were stood up in order to create a Covid-safe route—a non-Covid route—via the GP for people's healthcare needs. It was a successful attempt by us to ensure that people who had healthcare needs could continue to be seen and treated by their GP; although that often happened digitally, it meant that the GP practice was Covid free and those individuals who had symptoms of Covid could be assessed through the hubs and, if necessary, seen and treated in the assessment centres.

Given that we now have the infrastructure, it would be crazy to disband that and go back to the old ways. In consultation with GPs, community pharmacy and other clinicians in secondary and tertiary care, we must identify an appropriate use of that infrastructure, so that we can see people, as George Adam said, for whom the GP's office might not be the first port of call. Equally, A and E might not be the right port of call; how can we assist in that situation?

Alongside all that goes the work that Ms Haughey is leading, which is a redesign and transition into a new shape of the delivery, in particular, of crisis mental health services. A and E is not the right place for individuals in those circumstances, but they are in crisis, so an emergency response is needed. We saw some of that work through the pandemic, including a good example in NHS Greater Glasgow and Clyde; it is about developing that alongside other health boards. That is an example of lessons that we have learned in a response to the pandemic that was very rapid but which produced important new ways of working and new practice in the delivery of healthcare.

George Adam: I have a final question. As we look at how we might work differently in the mid to long term, we might look at putting money towards hubs, as opposed to traditional methods. What impact could that have on primary care funding in the mid to long term?

Jeane Freeman: We had made good progress towards delivering more than half of spend to our primary and community health services in this financial year. We had got to 49.7 per cent of funding in 2018-19. The figures for 2019-20 have been delayed, but we expect them early next year. We were making good progress in that area, and I am determined that we will continue to do so.

We recognise that the remobilise, recover and redesign NHS work that we commissioned from our boards will not move at the pace that we would ideally wish, because we still have a pandemic on our hands. However, when I commissioned the boards to do that work, I was clear that I wanted to see a significant focus on the delivery of healthcare in primary and community care settings and a much closer link—using the experience of the pandemic and partnership working—between health and social care. For example, we should continue the wraparound primary care service to our care homes in that more systematic way that we have seen through the pandemic.

There are significant opportunities, which we need to continue to drive forward on, to refocus healthcare into primary and community care that is more local to people and which makes maximum use of pharmacies and other services, so that acute care becomes exactly that: the place where people need to go when clinical treatment cannot be offered safely to them in any other setting.

David Torrance: How is the NHS Louisa Jordan hospital currently being used, and is it providing value for money?

Jeane Freeman: The NHS Louisa Jordan remains in place, as you know. We have extended

the licence on it until April next year to ensure that we continue to have that additional resource should we need it in the face of increased Covid cases, or to assist us in working through the outstanding healthcare needs, as it is currently doing. The hospital has been used for orthopaedics and plastics patients. It is also being used for a degree of diagnostic work and for staff training, teaching and examinations. It is important that staff can continue to follow their training and learning, which have been disrupted because of the pandemic and the response to it. It is very important to have a known Covid-free space where clinics and facilities can be made available.

We will continue to use the NHS Louisa Jordan for that. We are considering what more can safely be done there for patients through day-case surgery and other healthcare procedures as well as diagnostics. Having invested in the build of the Louisa Jordan, which was completed very quickly and within budget, it makes considerable sense to give ourselves the security of knowing that it will be with us at least until April next year. We can maximise its use for the NHS—whether or not it is for Covid, it is still for the NHS and for patients.

David Torrance: Given the potential for a second wave of Covid-19 infections, is the NHS Louisa Jordan a good example of pandemic planning by the Scottish Government, and is it ready to treat Covid patients if needed?

Jeane Freeman: It is a good example of the right kind of planning that needs to be done, for two reasons. First, it was established to deal with Covid patients should our standard NHS estate require that additional resource, and it remains ready to do so if required. However, until it is required to do that, it is also there for us to use to deal with a backlog of patients who could not be seen in the months when we were dealing with the pandemic at its worst. At this point, it feels to me to be a good use of additional resource, and it is making a difference to patients in Scotland.

Brian Whittle: My questions are on the preparations for a potential second wave of Covid, which unfortunately seems to be on its way. It is fair to say that, the first time round, Governments were not particularly well prepared for the eventuality. What funding has been made available to support preparations for a potential second wave of the virus this winter?

Jeane Freeman: Excuse me, Mr Whittle, while I just nip back into my papers to check that.

At the moment, we have set aside £0.3 billion for second-wave preparedness. A lot of planning is going on. Earlier, I mentioned the board mobilisation plans. Those plans are caveated, in that boards have also been asked to retain capacity in bed numbers in intensive care units, in case there is a significant increase in hospital admissions as a result of Covid. They will maintain their red and green pathways, of course, and they are also contributing to controlling the spread of the virus through the NHS test and protect programme. Our boards will lead our flu vaccination programme this year, covering 2.25 million people.

Social care is also looking at what more it needs to do in terms of winter preparedness. Subject to the agreement of the Parliamentary Bureau, I hope to be able to set out some of that in detail to the chamber before the October recess.

Winter planning is a normal part of what happens every year but, this year, the planning is going on in the context of a pandemic, with a virus that is still as capable of causing significant harm as it was in the spring. As I say, boards have undertaken that work knowing that they need to hold a degree of capacity ready—not empty right now, but ready to be stood up if it is needed.

At the same time, NHS National Services Scotland, our national procurement service, which is responsible for personal protective equipment, has been ordering its PPE supplies, using the model of demand that was there in the peak months and retaining all the distribution outlets and routes that it had before.

I should also point out that boards will have to be planning for Brexit and the possibility of no deal. That includes work with our counterparts across the UK, looking to ensure that we have medicine supplies and stocks and that we can prepare as best as we can in those circumstances.

Brian Whittle: We heard from NHS Ayrshire and Arran that, if there was a significant second wave, there would have to be a similar cessation of activity in order to implement the safety precautions that would be required. That would involve the cessation of the right to treatment. What are the cost implications of that? Also, what would be the trigger for returning to those kinds of lockdown measures?

Jeane Freeman: The question of what would be a trigger is asked a lot, and I think that it was raised at your meeting with Mr FitzPatrick. I genuinely wish that there were a magic number or indicator that we could point to and say that, when we reach that level, we will do X or Y. Unfortunately, it does not work like that.

We look at a number of indicators every day and weekly. You will be familiar with them. They include the number of cases; where they are; what has produced them; the level of modelled infectiousness in the community, which involves the surveillance work that Roger Halliday and his colleagues publish on a weekly basis; and what the R number looks like. There are a number of

factors to be taken into account before we would conclude that we had a level of community transmission that would constitute a second wave.

At this point, although our case numbers are high, they are in outbreaks rather than in community transmission. The complete focus just now is to contain those as much as we can, just as we did in Dumfries and Galloway and in Aberdeen and in relation to the 2 Sisters Food Group outbreak, and to try to take additional measures that ensure that, as we try to contain the outbreaks, we also protect against community transmission. There is a twofold approach. I am sure that I will discuss some of that with the COVID-19 Committee tomorrow. There is not a trigger or a number that I can give you, but I hope that my explanation is reasonably clear.

12:00

We are also considering the different scenarios for when hospital and ICU admissions grow to those kinds of levels, and what that would mean for the cessation of other work. I am trying hard not to get us into a position in which we simply stop doing as much as we stopped doing last time. That is partly informed by the fact that we have test and protect at the scale that we have it, we have a growing understanding of the virus and how it operates and who it impacts on, and we can look across Europe and see that, although we are going through an outbreak that is largely concentrated in the younger age group, we can anticipate a lag, but we will also see increased hospital and ICU admissions.

Taking all those factors into account, how might that work for us in terms of having to halt the healthcare services and procedures that we have begun to remobilise? We also need to bear in mind the fact that boards plan six weeks ahead for elective work, for example. Patients are getting appointment times up to six weeks into the future, but that is the planning cycle of health boards. We need to take decisions fairly early if we want to stop something that has already been planned for six weeks into the future.

Mr Whittle, that is not a definitive answer, but it is the best explanation that I can give of how we are trying to work our way through this while understanding what is happening with the virus in the community and in the outbreak areas, and what that means for the health service, alongside trying hard not to get back to a place where we cease activity across a whole range of areas.

Brian Whittle: You can correct me if I am wrong, cabinet secretary, but I think that what you are saying is that any return to lockdown will be decided predominantly on the basis of general community transmission, not outbreaks, and that is very helpful.

The question that I really want to ask is this: what would the financial requirements be if we moved to the cessation of elective treatments, and what are the cost implications of keeping NHS Scotland on an emergency footing?

Jeane Freeman: Mr McCallum might be able to help here. As I indicated earlier, there is a degree of saving to be made if we stop doing elective work, for example, and redeploy staff into other areas. We know what the cost of dealing with a pandemic has been so far—our quarter 1 conclusion has told us that. Those are the numbers that we have to work from when planning what the cost of any second wave might be.

Of course, it is not and it cannot be clear at this point when a second wave might appear. Our current overall objective is to ensure that such a thing does not happen because of the effective deployment of test and protect, and the increased compliance of the public, who have already complied so very well with the restrictions that we are asking them to comply with to prevent transmission.

We need to plan as best we can for the detail of how we would respond to a second wave, and our estimate of the cost of that must be based on what we know has been the cost of dealing with the pandemic so far. Mr McCallum might want to say some more on that.

Richard McCallum: I will just pick up on the cabinet secretary's point that there will be some short-term savings as a result of not providing some services. I expect such savings to be fairly negligible, as most costs for health board are staff and bed costs, and they are fixed by nature.

We need to work through the impact of the delays of elective treatment in future years and the potential financial implications for future years. Obviously, finance is not the only factor in that; there will be questions of capacity and other issues. Looking beyond the current pressures, we need to see where we are going to be as we come out of winter and how that will be managed. A key part of that will be the approach to the elective centres and bringing those on stream to deal with some of the backlog. That is a key focus of both our capital and revenue investment for 2021-22 and beyond, and it will be a key driver in supporting our elective strategy beyond this winter.

Sandra White: You have possibly answered several of the questions that I was going to ask about the innovative way in which we are working now. You answered George Adam's questions in such a way as to answer the questions that I was going to ask about delivering the Near Me service

and digital services, so I will move straight on to the budgetary point. Cabinet secretary, you said that you prefer care to take place in the community where possible, with less reliance on hospital-based care. We do not have a crystal ball, and we do not yet know what the budget will be, but if those innovative services are retained and we have new care models, will there be savings in the health budget in the future?

Jeane Freeman: No, I do not necessarily believe that we will have financial savings in the health service budget. There will be a continued focus on moving spend into the community and primary care. Acute care develops all the time, and we know that precision medicine and genomic science produce significant advances, which are primarily seen in acute care. I can recall the days when having a hip operation meant weeks in hospital. Now, in NHS Fife, depending on the nature of the hip replacement to be undertaken and the patient's health, some operations can be done as a day case. Therefore, advances in science will result in improvements in patient care, pain management and pain relief. We will see improvements in that people will receive the right care closer to home but, at the same time, we will see the effect of medical advances coming through in acute care particularly. That care will not be cheaper than what we had before, but it will be better for patients, because their stay in hospital will be shorter, and it will be possible to see more patients if one patient does not need to occupy a bed for a week but is only in hospital for two to three days, which I think is probably now the standard at the Golden Jubilee hospital. I am not convinced that those improvements will necessarily produce significant financial savings, but they will produce a continued improvement in patient care.

Sandra White: Presumably, that will result in an improvement in wellbeing, which is what we all want. Have you considered patient views in looking at different innovative ways of working? Are we going to ask patients for their advice about models of delivery or ask them how they feel about those and evaluate the outcomes?

Jeane Freeman: I do not have the survey to hand, but the people in charge of the Near Me service technology and method of service delivery undertook a survey with clinicians who had used the service, primarily in primary care but also in acute care, and with patients who had used it. They have produced the results of that work, which show that patients overwhelmingly prefer that way of consulting their clinician, GP or whoever. It does not remove the need for face-to-face consultation, on the part of either the clinician or the patient—if that is what the patient prefers—but it has proved itself to be a significant addition to the delivery of care over the course of the pandemic.

Other evaluation work and surveys will be undertaken on other ways of improving the delivery of care. As you know, Health and Social Care Alliance Scotland is a member of the mobilisation recovery group that I chair and it has been tasked with finding out from patients what they would like their NHS to look like and how they would like to see their healthcare services delivered.

Sandra White: Thank you. I would certainly like the committee to get a copy of the results that the cabinet secretary mentioned.

My last question is about office workers, call centre workers and so on working from home. Health boards have told us that more and more staff who are not involved in front-line services are working from home. Do you think that there is a role for more centralisation of office-based functions? Returning to budgetary issues, do you think that that would be cost saving for the health service?

Jeane Freeman: Pre-pandemic, a number of our national boards looked at combining their finance and HR services and so on into a single operation. There was more work to be done on that but, inevitably, the pandemic paused a great deal of it, because we asked boards to focus on responding to the immediate challenge. Richard McCallum might want to say a bit more about that.

Richard McCallum: I would just add a couple of things. That is something that we always focused on pre-pandemic. Where there are opportunities to use the NHS estate more effectively, for example to bring back-office functions together, we will do that. I think that that will continue and we will continue to review that as we go through the pandemic. The cabinet secretary gave the example of the national health boards. NHS NSS, in collaboration with the Scottish Ambulance Service and Healthcare Improvement Scotland, has brought together functions at one site at the Gyle.

Boards are seeing the benefit of home working. Fairly recently, Microsoft Office 365 was rolled out across the health service, and having that capacity and functionality has really helped. Obviously, not all staff are in the position to work from home, but that roll-out increased the number of staff who can. On the back of that, territorial and national boards can look at using their estate more efficiently and effectively, and we will keep working with them on that.

David Stewart: Good afternoon. I have a couple of questions about financial stability and sustainability. The cabinet secretary is well aware that four boards—Tayside, Ayrshire and Arran,

Highland and Borders—received brokerage in 2019-20. I appreciate that the cabinet secretary does not have a crystal ball, but does she think that those four boards will break even in three years' time?

Jeane Freeman: Mr Stewart will recall that, at the onset of the pandemic, we paused the development of the three-year financial and savings plans for boards and integration authorities. We have now returned to those plans and are reviewing what can be delivered this year. Mr McCallum knows the detail of that.

12:15

The Convener: Mr McCallum—are you there?

Richard McCallum: Sorry, I dropped out of the meeting again. I missed Mr Stewart's question, but I think that it was on our approach to escalation with four boards. We will continue to work with those—[*Inaudible*.]

The Convener: I fear that Mr McCallum's connection is not strong. Let us revert to David Stewart, and then we might be able to bring in Mr McCallum again.

David Stewart: I would like to raise a more general point with the cabinet secretary. As she knows, I am genuinely interested in rural areas in particular. All the four boards that I have mentioned—apart from Dundee, which is a very urban area—have a strong rural component. I know from my experience in the Highlands and Islands that a number of boards in my patch have what I would describe as chronic structural financial problems. I think that the cabinet secretary is aware of what I am getting at. Staff turnover and vacancy levels are high. There are examples of consultants on £300,000 per year, locum staff still being essential, chronic drug overspend and management churn. Without me naming individual boards, the cabinet secretary knows exactly what I am talking about.

Is that something that the cabinet secretary would consider addressing when it comes to planning, albeit that the group was paused during the coronavirus crisis? Those chronic problems will affect the ability of those by-and-large rural boards to break even in three years' time.

Jeane Freeman: Mr Stewart raises a good and important point. There is much in the sentiment that he is expressing that I would not disagree with. Were we not in the middle of a pandemic, I would want to—and I did want to—have a better look, at whether we could address some of those structural issues in a different way as we do the long-term financial planning with our boards.

I think that it is important that we have a single national health service in Scotland, and that we do not have individual trusts and so on. However, that does not discount the fact that individual boards are dealing with very different circumstances as they try to deliver equity of access to healthcare to citizens across the country.

The boards that Mr Stewart is referencing have big geographical challenges. Those challenges differ between those three boards, but they are still significant. They are greater than, for example, the geographical challenges that some of our central belt boards have to deal with, but, equally, those boards have high population density and other challenges. We need to find a way to create stability across all our boards, but with a degree of flexibility that allows us to help them address the particular challenges that they face in their particular circumstances.

We have not been able to make a significant amount of progress on that at all, for reasons that I am sure Mr Stewart well understands. It is very important to log on the record that we want to be able to return to and begin working through that area.

David Stewart: I thank the cabinet secretary for the very positive tone that she adopted in that answer. There are two elements to my last question. Generally, I suppose that my political philosophy is about decentralisation of healthcare. I think that the cabinet secretary is well aware that one of my causes célèbres is the need for a positron emission tomography scanner in NHS Highland. As the cabinet secretary knows—because I lodged parliamentary questions about this—in one year that I looked at, the cost to NHS Highland for patients going out of region to Aberdeen, Dundee, Glasgow or Edinburgh was £400,000. I accept that PET scanners are expensive in terms of capital costs, but that is also a huge annual revenue cost that will not go away.

I suppose that part of what I am suggesting is more decentralisation. I know that your answer on the NRAC formula was that you do not believe that any change is necessary, but does the formula fully reflect the costs that rural health boards incur?

Jeane Freeman: I think that I partly answered that in my answer to your previous question. We need to find a way to have equity of distribution of funds across health boards, but with a degree of additional flexibility that allows us to recognise the particular challenges that rural health boards face, which are different.

As I have said, the challenge for NHS Highland is less about population density. On the contrary, it is about the board having a population that is dispersed across a large geographical area, and what that means for the health care services that the board can provide, the cost of those, the

staffing issues that Mr Stewart addressed, and where it is appropriate to centralise the delivery of services.

That is not necessarily about cost; often, it is about clinical safety. We want our clinicians to be able to work with a volume of patients because that enables them to continue to keep their skill levels high and improves the safety of what they do, so some healthcare is inevitably more central.

Equally, health boards in the central belt have challenges in relation to population density and high levels of health inequalities, and we need to fund them, as far as we can, so that they can respond to those and other challenges.

The problem that I have with formulas, which I think we all have, is that we will never get a formula that works perfectly for everyone. That is not to say that the current formula should never be looked at, but I think that we need to take on board, if you like, the sentiments behind Mr Stewart's question—as I said, I would not have a great deal of disagreement with that—and see whether, within the single structure that is our NHS, which I passionately believe that we should keep, we can find better ways to address some of the issues that he raised.

Brian Whittle: In October 2018, the Scottish Government published "Health and Social Care: medium term financial framework", in which it identified the need to save £1.7 billion over the period from 2016-17 to 2023-24. You have indicated that the pandemic will have an impact on those plans over the period that the framework covers. When do you expect to be in a position to provide an update on the medium-term financial framework that reflects the impacts of the pandemic?

Jeane Freeman: Up until Covid, we were in line with the trajectory that is set out in the framework, with boards and IJBs having secured the necessary levels of savings and the portfolio being in a balanced position. We now intend to review the medium-term financial framework to take account of the impact of Covid, and I undertake to keep the committee informed as we do that work and update the framework. We will make sure that you are well aware of what we are doing and the outcome of that.

Brian Whittle: Now that the Government is pushing towards or approaching a regional approach to the planning and delivery of services, what progress has been made in respect of that? What savings will be or have been delivered?

Jeane Freeman: We were taking that approach, but being in the middle of a pandemic has significantly changed how the NHS responds, so many plans and intentions have been paused. We want to return to such work and develop it but, as with everything else that we have discussed, that depends very much on how successful we are in suppressing the virus and avoiding a significant second wave. I am not sure that I am particularly able to answer your question in detail at this point, but Mr McCallum might want to add more, provided that his connection is working.

Richard McCallum: I will add two things. As the cabinet secretary said, health boards have through the pandemic set out their own mobilisation and remobilisation plans, which we expect to continue. However, we expect boards to work together when that is possible and to work with each other when there are good grounds to do that.

I will give two examples. A group of NHS chief execs with one representative from each region and one from the national boards still meets to look at how we can respond to Covid on a regional basis when there are good grounds for that. Given that we are talking about the budget, and to go back to Mr Cameron's questions about scrutiny, I highlight that we have regional finance leads who look at the spend in regional areas. That ensures peer review of costs that are being incurred in the pandemic.

Work is still going on at the regional level. Some work has paused as we deal with the pandemic, but I expect that to pick up again in the coming months as we remobilise and renew.

The Convener: I am conscious of the time, colleagues, so I will press on to our last subject, which is integration. The Scottish Government's lessons learned report highlighted positives and negatives for integration in the past few months. What is your view of the integration system? Are there lessons to learn that might mean, for example, improving the structures for making decisions or allocating resources?

Jeane Freeman: The point is interesting. In the months of the pandemic that have been the most challenging so far—from March to June—because of the numbers of cases and the effect on remobilisation of services, chief officers and others consistently fed back to me the point that the decentralisation of decision making was an improvement. That meant that an IJB's chief officer did not have to secure the agreement of a number of committees before acting—they were empowered to take the right decisions to make things happen by using their professional judgment, in partnership with their colleagues in local government and the health board. The setting up of the PPE distribution hubs and our alertness to issues on the ground are testimony to how well that has worked. Discussion continues with chief officers of IJBs—it will shortly involve chairs and vice chairs, too—about whether the committee structures that are in place are still essential.

12:30

Our IJBs have perhaps overdone replicating committees that properly already exist in boards and local government for governance purposes, so I am not sure that we need a third tier of those. We will continue to discuss that with IJBs. Our board mobilisation plans expect boards to produce plans developed in partnership with local IJBs, which is what we have seen but to varying degrees of success, as you might expect. However, we continue to look for that improvement. We can learn lessons to improve the functioning of integration, but the principle remains correct.

Sandra White: The cabinet secretary's answers to the questions that you asked, convener, have covered most of the questions that I was given, with the possible exception of one, although I think that the cabinet secretary might have answered this, too. Work is under way to continue the progress in partnership working and transparency, as recommended by the ministerial group. How is that work going?

Jeane Freeman: Like so much of what we have talked about this morning, that work was progressing well until the ministerial group was paused when the pandemic took off. We have now reached agreement to take that work forward again, as all members of that group, apart from one or two, are now members of the remobilisation and recovery group, including IJB chief officers and representatives of the chair and vice-chair group. However, the focus at this point is on ensuring that remobilisation and recovery are integrated with the work of our boards and social care.

Sandra White: Thank you for that.

The Convener: Emma Harper is the final questioner.

Emma Harper: I am conscious of the time, so I will be brief. Health and social care integration is about shifting the balance of care from hospital to community. Do you expect a longer-term shift in the balance of care because of the coronavirus pandemic?

Jeane Freeman: Yes. We were well on track to shifting to that 50 per cent of spend, as I said in answer to an earlier question. I expect to see it in terms of delivery of community hubs and assessment centres, as I said in answer to Mr Adam, and in terms of the hospital at home programme, which has long been pioneered successfully by NHS Lanarkshire is now being picked up at pace by some other boards. That consists of the transfer of hospital-based care to people's homes, which has been done effectively, with significant patient satisfaction and positive healthcare outcomes for those patients. Other areas of shift include the near me programme, which was primarily adopted by GP practices but is now being picked up by many of our hospital-based clinicians for out-patient appointments, which it shifts from the hospital setting back into the community. A great deal like that is already under way as a consequence of people seeing how they could deliver services in the face of the pandemic and, in doing so, finding innovative but safe and clinically proven ways of delivering healthcare in the community closer to where their patients are.

Emma Harper: My final question might require a wider answer. The ministerial strategic group said that set-aside budgets were not working effectively. Obviously, the Covid pandemic has affected all budget planning for the future, so, do you think that we need to make adjustments to how set-aside is planned? I am happy to take a written answer if that would be beneficial, because of the time.

Jeane Freeman: We agreed plans with COSLA on making improvements to set-aside budgets. Alongside that—this is important—we agreed on much more effective use of IJBs' reserves, some of which are considerable, so that we could make better use of resources overall. Following that agreement, the plans were under way, but we then had the Covid pandemic. However, there is no disagreement between us and COSLA about the importance of that approach and of picking it back up as soon as possible.

The Convener: I thank the cabinet secretary and Richard McCallum for their attendance today and for helpfully answering the further questions that the committee had. I look forward to hearing a bit more detail about this morning's announcement, which is, of course, welcome. However, it is fair to say that it is a top-line announcement, so it will be interesting to see some of the detail behind it as we continue our pre-budget scrutiny.

We now move into private session.

12:36

Meeting continued in private until 12:51.

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