OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 9 February 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 9 February 2021

CONTENTS

HEALTH AND SPORT COMMITTEE
5th Meeting 2021, 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:

Jeane Freeman (Cabinet Secretary for Health and Sport)
Mairi Gougeon (Minister for Public Health, Sport and Wellbeing)
Sharon Grant (Scottish Government)
Michael Matheson (Cabinet Secretary for Transport, Infrastructure and Connectivity)
Richard McCallum (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 9 February 2021

[The Convener opened the meeting in private at 09:30]

10:45

Meeting continued in public.

Subordinate Legislation

Health Protection (Coronavirus) (International Travel, Public Health Information and Pre-Departure Testing) (Scotland) Amendment Regulations 2021 (SSI 2021/34)

Health Protection (Coronavirus) (International Travel, Prohibition on Travel from the United Arab Emirates) (Scotland) Amendment Regulations 2021 (SSI 2021/52)

The Convener (Lewis Macdonald): Good morning, and welcome to the fifth meeting in 2021 of the Health and Sport Committee. We began our meeting in private session and now move to the public agenda items. We have received apologies from Alex Cole-Hamilton.

I ask all members and witnesses to ensure that their mobile phones are on silent and that all other notifications are turned off during the meeting.

Agenda item 2 is consideration of two made affirmative instruments relating to coronavirus and international travel. The instruments have been laid under section 94(1) of the Public Health etc (Scotland) Act 2008.

The 2008 act states that regulations under section 94(1) are subject to affirmative procedure, but it also provides that the Scottish ministers may make regulations urgently, if they believe that to be necessary, in which case emergency regulations must be laid before the Scottish Parliament. Such regulations cease to have effect on the expiry of the period of 28 days beginning with the date on which the regulations were made unless, before the expiry of that period, they have been approved by a resolution of the Parliament. It is for the Health and Sport Committee to consider the instruments and report to Parliament accordingly.

Today, we will have an evidence session on the instruments with Michael Matheson, the Cabinet Secretary for Transport, Infrastructure and Connectivity, and his officials. Once we have asked all our questions, we will move on to the formal debate on the motions on the instruments.

I welcome to the committee the cabinet secretary and his accompanying officials from the Scottish Government. Craig Thomson is border measures review team leader, David Pratt is policy lead in the health performance and delivery team and Peter Brown is from the police enforcement, liaison and performance team.

I thank the cabinet secretary for joining us today. Given the nature of the regulations, we intend, with his agreement, to ask questions on both instruments in the same session and then proceed to debate the motions on them together. Questions may be general in nature, but a few will undoubtedly be specific to the terms of individual regulations.

I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Transport, Infrastructure and Connectivity (Michael Matheson): Thank you, convener, and good morning, everyone.

The country changes in the regulations are all related to the variant of Covid-19 that has been identified in South Africa. Four more African nations have been added: the Democratic Republic of Congo, Tanzania, Burundi and Rwanda. Those countries have been assessed by the joint biosecurity centre as being at risk of probable transmission of the new variant.

The United Arab Emirates was also made subject to the additional restrictions on high-risk countries. That is because cases of the South African variant have been identified in England that have a travel history in the UAE but not in Africa. The implication is that people have become infected with the new variant while in the UAE.

The regulations also restrict passenger flights from the United Arab Emirates, and there are also technical changes and clarifications relating to the passenger locator form, pre-departure testing and definitions of “aircrew”.

I am more than happy to respond to any questions that members may have.

The Convener: Thank you. Perhaps you could start by indicating your view of the South African variant and whether the provisions have been put in place timeously. Is it the Government’s view that they will prevent the spread of the variant in Scotland?

Before you answer that question, I ask committee members who wish to ask questions to enter an R in the chat box now.

Michael Matheson: The South African variant is one of several variants that are causing concern, given the way in which it can potentially re-infect individuals who have had Covid. There are therefore concerns about the possible implications of the South African variant for our vaccination programme.

It became clear from the evidence that the joint biosecurity centre provided that we had to move quickly to try to reduce the risk of the South African variant entering the United Kingdom. At that point, the decision was made to move to the red list system. Countries where the South African variant had been identified were put on the list, meaning that flights were banned and any UK nationals coming from those areas were required to self-isolate.

That was the initial approach, but it was clear from the clinical advice that I received from the chief medical officer for Scotland that it would not be adequate to further reduce the risk of the new variant's introduction and that we would have to move to a form of managed quarantine for those coming in from countries that are considered to be high risk. That is why we agreed to move towards using managed quarantine, or managed isolation, for those coming in from countries rated as red, or risk, countries.

However, from the discussions that we have had with the CMO, it is clear that a system that is designed to respond to the identification of new variants is a reactive system. We know where variants are only because of genome sequencing that takes place in a country. For example, we know about the variant in South Africa because that country carries out a significant amount of genome sequencing. The problem that the JBC and our chief medical officer have highlighted is that, often, mutations circulate that we are unaware of because of the lack of genome sequencing internationally. We can therefore further reduce the risk of the introduction of a variant such as the South African variant only by having a comprehensive system of managed isolation or managed quarantine.

That is why we made the decision, which the First Minister announced last week, that, rather than just having managed isolation for those returning from what are classed as risk countries, all international travellers arriving in Scotland will be required to use managed isolation. By doing that, we can help to reduce the risk further.

That approach has limitations, because there is cross-border flow between England and Scotland. I have made representations to the UK Government on that and said that we think that there should be managed quarantine across the whole UK, but the UK Government has taken a different view. However, we are taking forward an approach in Scotland that we believe is the most robust approach that we can take in the present circumstances.

The Convener: Thank you. David Stewart and Sandra White have questions.

David Stewart (Highlands and Islands) (Lab): Good morning, cabinet secretary. I have a wider strategic question. You might know of my interest in the development of an internationally recognised digital Covid passport. The idea has been raised by the Greek Prime Minister, is actively being considered in Europe and has also been raised by the Tony Blair Institute for Global Change. In a slightly ambiguous way, it has also been raised in the United Kingdom Parliament. As you will know, the idea is that a Covid passport will get the economy back to work, will be recognised across the world and will be a big boost to tourism. Frankly, it will happen with or without politicians, because companies such as Qantas are already introducing it.

I appreciate that there are technical issues and some civil liberties issues regarding a Covid passport, but we can see from the work that was done around the European health insurance card that such a thing can be done if there is a willingness to do it. You will be aware that the UK will host the G7, which will be a great opportunity to show leadership on the issue. What is the cabinet secretary's view? Has the Cabinet discussed the idea?

Michael Matheson: Good morning, Mr Stewart. I am aware of the idea of an electronic vaccine passport, but I am not persuaded that it is the right approach at the moment. Given the challenges that we face with new variants and our understanding of how the vaccine operates in respect of the transmission of the virus, I do not feel that, at present, the introduction of an international vaccine passport would be an appropriate alternative to the use of managed quarantine for individuals who are returning after international travel. It may have a role to play at some point in the future, but we are not at that point yet.

I agree that there are some civil liberties issues that have to be worked through. For example, there could be a good reason why someone has not taken up a vaccine from the vaccines that are available.

It may be that, at some point in the future, a vaccine passport would have a role to play in helping to support international travel. However, I do not believe that, at present, it would be a way for us to reduce the risk of the importation of new virus and new variants.

David Stewart: I appreciate the cabinet secretary's honesty and openness on the issue. I

simply make the wider point that it is not a zero-sum game—in other words, a passport could be an additional longer-term strategy. No one is suggesting that it would be an alternative to quarantine hotels.

With regard to civil liberties, I was interested to find out that in America, where my son happens to live and work, in situations where individuals had not gone ahead with the measles, mumps and rubella vaccine—as we know, there were some issues in that regard—nurseries and schools refused to accept young people who did not have the vaccine. In a sense, the issue of whether or not people choose to have the vaccine is not for us to consider today; I merely make the point that there will be implications and effects as a result of such decisions. I therefore see a vaccine passport as an additional long-term strategy, not as an alternative to test and trace or to quarantine hotels.

Michael Matheson: I agree with David Stewart on that. It could be one of a number of aspects that could form part of a longer-term strategy to support a return to international travel. The challenge will be to identify when we arrive at that point. The reason why that is a challenge is because different countries will be at different points in their vaccination programmes and in suppressing the virus, and they will take different approaches in how they go about achieving suppression. I agree that international co-operation will be needed in introducing such a scheme, but we have to wait until we arrive at a point where we think that it may be right to introduce it.

As part of a longer-term strategy and as one of a suite of measures that we can put in place to support international travel when it is safe to do so, a vaccine passport could have a part to play.

Sandra White (Glasgow Kelvin) (SNP): Good morning, cabinet secretary. I have some questions on quarantine hotels, if that is what we are calling them. I acknowledge what you have said about the JBC highlighting the need to reduce the risks. To my mind, we should have locked down international travel a lot earlier, but we are where we are.

I am interested to note that, while we in Scotland are talking about international travellers who come up to Scotland via Heathrow or wherever having to isolate in quarantine hotels, Westminster does not agree with that approach. I am disappointed about that. What impact will there be with regard to international travellers who come into Scotland via Heathrow? How will that be managed? Budget-wise, will the Scottish Government be responsible for paying for quarantine hotels if Westminster is not on board with what we wish to do?

Michael Matheson: Sandra White will be aware that I will be making a statement to Parliament to set out some more details of the methods and process for taking forward managed isolation over the next week. I believe that a comprehensive UK system is the safest and most effective way to reduce the risk of the importation of new virus or variants into Scotland and the UK as a whole, and is in all our interests.

11:00

The UK Government has decided to take an approach to the issue that is different from ours, and to target managed quarantine only at those who come in from the red list high-risk countries. We will introduce managed quarantine for all travellers who arrive at Scottish airports from an international destination. It is clear that a challenge remains around those who arrive at English airports and travel on to Scotland. We are working with the UK Government to see whether we can introduce a mechanism that would allow those individuals to carry out their managed quarantine at the point of entry into the UK, no matter where that is, but we have not been able to get agreement on that.

The system that we are putting in place is the most comprehensive that we can put in place, given our powers and the scope of our ability. However, if it were applied at the UK level, that would make it even more effective. We are continuing to discuss the issue and to ask the UK Government to consider expanding its approach in order to capture a greater number of people who come into the UK as a whole. Members can be assured that we are taking forward an approach that we believe is the most effective means by which we can reduce the risk of importation of new virus and new variants into Scotland.

The cost—it is a fixed cost—is borne by the traveller who uses a managed quarantine hotel or managed isolation. We will underwrite hotel provision. We will block book the hotel facilities through a joint agreement with the UK Government, so that there is one contract for all the hotels—that is being taken forward on our behalf. Hotels will be block booked to the levels that we believe are necessary. Those who will have to use them will have to pay the daily rate that goes with that. Part of the money will therefore be recovered from those who have to use the isolation hotels.

Sandra White: I apologise: my internet went down for a couple of minutes.

I have a follow-up question. How will those travellers be identified? Will people who are getting on a flight be asked questions? Will they fill

in something to say that they are travelling on from Heathrow, for instance, to Scotland?

Michael Matheson: A person who comes to Scotland on a flight will need to have completed a passenger locator form, which is a digital Home Office form. That information will be passed on to Health Protection Scotland. We will get information about individuals who travel directly to Scotland from an international destination from the Home Office, and that will allow us to identify individuals who require to use managed isolation.

Emma Harper (South Scotland) (SNP): Good morning, cabinet secretary. I want to pick up on what Sandra White said about managed quarantine. I have an interest in internal flights and on-going travel, whether that is by air or even by ferry. A person could go to Dublin from an international destination, for instance, and into Scotland through the port of Cairnryan.

I appreciate that you will make a statement this week. Last summer, we almost had zero Covid in Scotland. I agree with Sandra White that travel restrictions should maybe have been put into place months ago to prevent people from coming in.

How much pressure can you put on the UK Government to show that, for managed quarantine, the first stop for an international arrival needs to be the place where virus transmission can be really reduced? That is a concern for me, because any on-going travel poses a risk of virus transmission.

Michael Matheson: You make a good point about the risk of onward transmission. The most effective means of quarantining is at the point of entry to a country rather than waiting until travellers get to their end point, for the reasons that you outlined, which relate to the risk of transmission from someone travelling by whatever means to their end point.

The point of entry is the best place for quarantining. We have made representations to the UK Government, with which I will have a further meeting on Thursday, when we will cover such issues. There are different views about how to proceed, but we will continue that engagement and continue to explain that the system should be more comprehensive across the UK, because that is the most effective means of dealing with the spread.

You made a point about people coming from and moving around the common travel area, which includes the Republic of Ireland. We have raised that issue, as have the Welsh Government and the Northern Irish Government, and the UK Government is now engaging with the Irish Government. The COVID-19 Genomics UK Consortium report that was published at the beginning of December highlighted that a significant amount of virus importation into parts of the common travel area came from people moving between Scotland and England and between England and Scotland and elsewhere.

We must continue to look at what measures we can put in place to reduce that risk further. We are keen to establish a means of helping to reduce the need for people to travel around the UK. However, we are some distance from agreeing on what that would involve.

Given the evidence from the COG report, there is no doubt that progress needs to be made on the issue. We continue to discuss that with the UK Government. All four nations of the UK recognise that action needs to be taken; the question is about the method for acting to address the issue.

Emma Harper: I am curious about one issue. When we talk about managed quarantine hotels, what projected numbers are we talking about? Will tens, hundreds or thousands of people need to be put up in hotels?

Michael Matheson: I am in danger of pre-empting my statement to Parliament this afternoon. Three airports in Scotland—Glasgow, Edinburgh and Aberdeen—still receive international arrivals. Some are more associated with the oil and gas industry—that applies particularly to Aberdeen. We are working to project numbers on the basis of the number of international travellers into Scotland per week. We are looking to have managed isolation available for those who need to undertake it. Some individuals will be exempt if they have a critical role in a certain sector—for example, if they are air crew. The scheme will have exemptions, but we are modelling a system that is based on the number of individuals who have travelled into Scotland in the past couple of weeks. We will ensure that we have sufficient rooms available for those who will have to complete managed isolation.

Brian Whittle (South Scotland) (Con): I will follow on from Sandra White's questions about the Scottish Government's requirement for everybody to go into quarantine after international travel. My question is about onward travel on an internal flight after an international flight—Emma Harper raised that issue. Surely we have a system in place that tracks the origin of travel. We must be able to do that quite simply, so that when people arrive in Scotland, no matter where they have flown in from, we should be able to identify them and ask them to quarantine.

Michael Matheson: The passenger locator form, which the Home Office put in place, is the way in which we get that information. Every traveller coming into the UK is required to

complete a passenger locator form before they arrive. It sets out where they have travelled from, where they have travelled through, and where they are going.

If someone is transferring through Glasgow from Heathrow after an international flight, we would have that information on the individual. However, my preferred system would be for that person to carry out their managed isolation at the point of arrival, rather than go on to a domestic flight and complete their managed isolation at their destination. There are very obvious reasons for that, including the risk that it creates. That is one of the points of discussion that we are continuing to pursue with the UK Government. We would prefer those individuals to complete their managed isolation at their point of arrival into the UK rather than at the end of their journey.

The PLF is the form that provides us with the data and information on individuals who might be required to carry out managed isolation.

Brian Whittle: I understand that you are saying that you would prefer those people to isolate at their place of entry into the United Kingdom, and that there is a difference of approach. Is there any way in which the Scottish Government can insist that someone like that cannot board an internal flight following an international flight until such time as they have been quarantined? Is there any way in which we can insist on that, if you like?

Michael Matheson: The system depends on the passenger putting the correct information about where they are going and whether they are going on to an internal flight on the PLF in the first place. If they have come by road or by bus, they might not complete the details of their end point. For example, they might land in London and travel on from there but not give that information. There are, therefore, some challenges within the system.

To make what you suggest a requirement would require the UK Government to make regulations to require travellers who are looking to travel on to Scotland to complete their managed isolation at a hotel in England. Legal provision would need to be made by the UK Government to facilitate that. That is part of the discussion that we are having with the UK Government. In our view, the UK Government should be looking to put that in place, but we cannot force it. The UK Government will have to agree to implement that, because it would require legislation.

Brian Whittle: Thank you.

The Convener: There are no further questions. I am confident that Michael Matheson will have enough new information this afternoon to satisfy the Presiding Officer in his statement.

We now move on to the next items on the agenda, which are the formal debates on the main affirmative instruments on which we have just taken evidence. Are members content with a single debate being held to cover both of the instruments?

Members are content. We therefore move to the debate. We are no longer in question-and-answer mode. I invite the cabinet secretary to speak to and move the motions.

11:15

Michael Matheson: Given the discussion that we have already had, I will go straight to moving the motions.

Motions moved,

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel, Public Health Information and Pre-Departure Testing) (Scotland) Amendment Regulations 2021 (SSI 2021/34) be approved.

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel, Prohibition on Travel from the United Arab Emirates) (Scotland) Amendment Regulations 2021 (SSI 2021/52) be approved.[—*Michael Matheson*]

The Convener: Does any member wish to contribute to the debate? Brian, do you want to come back in, or does your request to speak relate to the question session?

Brian Whittle: It relates to the debate. I want to highlight that, given the discussion that we have had with the cabinet secretary, and the straightforward way in which he has answered all the questions, the issue that is raised again is our inability, technically, to do what should be quite simple—to track somebody who is coming into the UK, and their onward travel. From a technical perspective, we do not seem to be able to deal with that. That was my only point.

The Convener: Thank you very much. No other members have indicated that they wish to contribute to the debate, so I invite Michael Matheson to sum up and respond.

Michael Matheson: Convener, I recognise the concerns that Brian Whittle has raised. That is why we need to continue to work with the Home Office—[*Inaudible*.]—the passenger locator form and how that information is shared with us. The matter is a concern for us and is part of our on-going discussion with the UK Government. I assure the member that we will try to identify ways in which we can improve the system and how it operates.

The Convener: Are members content that we put a single question on the motions? I can see that members are content.

Motions agreed to,

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel, Public Health Information and Pre-Departure Testing) (Scotland) Amendment Regulations 2021 (SSI 2021/34) be approved.

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel, Prohibition on Travel from the United Arab Emirates) (Scotland) Amendment Regulations 2021 (SSI 2021/52) be approved.

The Convener: That concludes discussion on those made affirmative instruments.

Human Tissue (Authorisation) (Specified Type B Procedures) (Scotland) Regulations 2021 [Draft]

11:16

The Convener: The next item is consideration of more subordinate legislation—this time, a draft affirmative instrument.

For this item, I welcome to the committee Mairi Gougeon, the Minister for Public Health, Sport and Wellbeing, who is accompanied by Sharon Grant from the health protection division and Caroline Mackintosh, from the legal directorate of the Scottish Government. I thank you for joining us today and invite Mairi Gougeon to make brief opening remarks on the instrument.

The Minister for Public Health, Sport and Wellbeing (Mairi Gougeon): Thank you for the opportunity to make opening remarks.

I think that it is important—and I hope that it will be helpful to the committee—that I set out the context in which the draft regulations have been laid. The committee will be aware that the Human Tissue (Authorisation) (Scotland) Act 2019 introduced a statutory framework for the authorisation and carrying out of medical procedures that facilitate transplantation, which are termed "pre-death procedures" in the act. They are defined in the act as the medical procedures that might be carried out on a person for the purposes of ascertaining the suitability of an organ for donation or of

"increasing the likelihood of successful transplantation ... after ... death",

and which are not for the purpose of

"safeguarding or promoting the physical or mental health of the person."

The committee will recall that, in cases of donation following circulatory death, which account for around 40 per cent of deceased organ donation, such procedures must be carried out before, sadly, the donor dies.

The framework for carrying out pre-death procedures is an important part of the new legislative regime for donation and, essentially, provides transparency for the public about such procedures, which are already a necessary part of the donation process in order to ensure the health and safety of organs for the transplant recipient.

I turn to the regulations. Parliament passed equivalent regulations for type A procedures in March last year. Those procedures are more routine and less invasive, and are regularly carried out in order to facilitate transplantation.

In some circumstances, if the clinical situation requires it, further diagnostic procedures are available to clinicians to assess the health and safety of organs—for example, if there is a possibility of malignancy, which requires further investigation. The type B regulations, which are now before you, list those procedures that, unlike type A procedures, are not expected to be frequently carried out in order to facilitate transplantation but might sometimes be required as part of the donation process.

Such procedures are not unusual in the wider context of patient care in a hospital setting. However, because of their non-routine nature in the context of transplantation, and the fact that they are more invasive than type A procedures, the act permits the setting in secondary legislation of additional safeguards that must be met before a type B procedure can be carried out.

I will briefly set those out. The regulations include a requirement that, unlike type A procedures, which are authorised automatically by virtue of the donation itself being authorised, a type B procedure must be explicitly authorised before it can go ahead. Given the circumstances in which donation takes place, in which the patient will usually be unconscious in an intensive care unit, that authorisation will be sought from the patient's family. Further, in line with the approach that is taken in the 2019 act, before that authorisation is given, the views of the potential donor must be taken into consideration so that such procedures are not carried out if they would be against the donor's known wishes.

As well as requiring that explicit authorisation, the regulations require that, further to the safeguarding conditions in the 2019 act, two conditions have to be met before a type B procedure can be carried out. First, the regulations state that a type B procedure can proceed only if two doctors agree to the procedure being carried out, having both considered that all the conditions set out in the 2019 act have been met. In feedback from the consultation, stakeholders requested that the regulations specifically exclude doctors who are involved in the transplantation process from performing that role, and that is reflected in the

regulations. The regulations also require that one of the doctors must be the doctor who is responsible for the patient's care. Those requirements reflect current practice in decision making on a patient's care in relation to donation, and they provide certainty and transparency around the process.

The second condition is that in order for the procedure to be carried out, the two doctors must also conclude that a lesser intervention—a type A procedure—cannot be used to provide the necessary information for transplantation purposes. That reflects the general approach to the carrying out of medical procedures and ensures that the minimum intervention is made to facilitate the transplantation.

Those additional conditions, taken together with the requirements in the 2019 act and the requirement for explicit authorisation, seek to ensure that, in cases in which it is necessary to carry out a type B procedure so that an organ can be safely transplanted, there are appropriate safeguards in place to ensure that the interests of the donor are protected. In practice, the requirements in the 2019 act and in the regulations mean that a type B procedure will not go ahead without family involvement or authorisation, and that it will not go ahead prematurely or if it is not absolutely necessary to facilitate transplantation.

In developing the regulations, we have worked closely with and taken the advice of clinicians who work in intensive care and across the donation and transplantation pathway. I am grateful for their input in helping to ensure that the specified procedures and additional requirements that we have in place are appropriate. We also consulted publicly, and the draft regulations before the committee take into account the responses to that consultation. I am happy to take questions from the committee.

The Convener: Thank you, minister. The committee took a good deal of interest in the matter when the Human Tissue (Authorisation) (Scotland) Bill was before us two years ago. I invite members who wish to ask questions to type R in the chat box in the usual way. We start with questions from Sandra White.

Sandra White: I certainly took a great deal of interest, as did members of the public, in the type B pre-death procedure. It came as news to me, not being a medical professional, and I think that the committee did a good job of looking into the situation.

I am happy with what the minister has said. The committee looked at the additional conditions with regard to doctors. The consultation was very important with regard to issues around patients, the families, authority and so on.

During the consultation, some religious groups were still concerned. Do we know whether any people or groups who were involved in the consultation are still not happy with the procedure? As I say, I am not moving against it—I think that the committee has done a grand job—but I wonder whether some people still have misgivings on the issue.

Mairi Gougeon: In developing the draft regulations, we took into account a lot of the points that had been made during the consultation process, and we tried to make the whole process a lot more transparent. As a result of some of the issues that came out of the consultation, we put in place, along with some other changes, extra conditions to require registered medical practitioners to authorise the type B procedures and to specify who those practitioners should be.

Sandra White mentioned the religious element and some concerns around that, too. That aspect was, of course, taken into consideration throughout the consultation process. My officials might have more to add on that point.

The Convener: Would Sharon Grant like to add anything on that?

Sharon Grant (Scottish Government): We sent a consultation specifically to faith groups and we did not receive any responses.

Our implementation team has been carrying out a series of webinars, on a weekly or fortnightly basis, with the help of Kidney Research UK. They are held with Muslim, Sikh and Hindu faith groups and faith leaders, who explain the content of the 2019 act and what tests can take place. I am taking part in one today after this meeting. So far, no one has asked any questions specifically about pre-death procedures.

It might help the committee to know that we have a mail drop to every household in Scotland. The letter goes into detail on the type A and type B procedures, so that the public will be aware of the whole donation pathway.

Sandra White: Thank you.

Emma Harper: Minister, the final words in your statement might have already answered my question. As a former liver transplant nurse, I know that many specialists are involved in communicating with family members about pre-death procedures. My question has to do with the transplant specialists and the teams that are engaging with family members—especially those of minority groups, which Sharon Grant mentioned. The legislation will ensure that specialists will be given adequate education to update them on the specific provisions for type A

and type B procedures. I am sure that the clinicians are knowledgeable already, but are they being given the support that they need to carry out their specialist jobs?

Mairi Gougeon: Yes, a lot of training has been done. I add that type B procedures in particular are rarely used, and, because of the conditions in the regulations, explicit authorisation is needed for the procedures to proceed.

My officials might want to come in again on this point, but I know that a lot of training has been done. NHS Blood and Transport has on-going training and additional support. There is also an e-learning tool, which I know that people have found really useful so far. That process is under way and will continue.

Sharon Grant: Comprehensive training on the whole 2019 act is taking place, as well as on the pre-death procedures framework. Clinicians have told us that they are really pleased with the training so far. All the training is now being done online. We, NHSBT and the Scottish National Blood Transfusion Service are also offering additional training and support to clinicians. As the minister said, we have developed an e-learning tool, with which the clinicians are really happy. It explains the processes and is something that they can use whenever they are not sure about some aspect. That will be accompanied by supporting guidance.

The Convener: As members have no further questions, we move to agenda item 6, which is the formal debate on the SSI on which we have just taken evidence. As normal, I invite the minister to move motion S5M-23852. If any member wishes to contribute to the debate, they should enter an R in the chat box.

Motion moved,

That the Health and Sport Committee recommends that the Human Tissue (Authorisation) (Specified Type B Procedures) (Scotland) Regulations 2021 [draft] be approved.—[*Mairi Gougeon*]

Motion agreed to.

Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2021 [Draft]

11:30

The Convener: The seventh item on our agenda is consideration of more subordinate legislation—another draft affirmative instrument. I again welcome Mairi Gougeon, the Minister for Public Health, Sport and Wellbeing and her officials from the Scottish Government. On this occasion, she is accompanied by Iain MacAllister, who is deputy director in the mental health and social care directorate; Paula Richardson, who is a team leader in that directorate; and Carolyn Magill, who is a solicitor and head of the social care, NHS workforce and structures unit. I invite the minister to make a brief opening statement.

Mairi Gougeon: As was noted at your committee last year,

"Health and social care partnerships are not designated as first or second responders in the Civil Contingencies Act 2004, which governs the overall structure of the resilience programme for local, regional and Scottish resilience partnerships."—[*Official Report*, *Health and Sport Committee*, 7 June 2020; c 5.]

Therefore, although integration joint board chief officers have already been contributing to local emergency and resilience planning—including, notably, during the Covid-19 pandemic, in areas such as personal protective equipment hubs and supporting those who are shielding—they have done so formally only through their roles as directors of health boards and local authorities, and without the appropriate reference to their accountable officer status in the integration joint boards.

Following that meeting in 2020, the Cabinet Secretary for Health and Sport confirmed to the committee that, given our recent experience of mobilising services to respond to Covid-19, it is recognised that IJBs should be included as responders in the Civil Contingencies Act 2004 and that we would make arrangements for that change to be made in legislation. We subsequently laid the SSI on 18 January 2021.

As the committee will be aware, the integration joint boards are responsible, as a minimum, for planning a significant proportion of the adult health and social care functions that are being delivered. Ensuring that IJBs are at the centre of emergency planning enables all the bodies that are accountable for community health and social care services to be appropriately represented.

By including IJBs as category 1 responders, we will ensure that, where there is risk of an emergency that will impact the functions that are delegated to IJBs—including in relation to our on-going pandemic response—formal, co-ordinated and appropriate arrangements will be in place for emergency planning, information sharing and co-operation with other responders, as well as for joined-up information sharing and advice for the public. The amendment to the 2004 act will therefore provide an overall structure for resilience planning that will ensure that our health and social care partnerships are built into the framework.

A consultation about including IJBs as category 1 responders took place on Citizen Space between 12 October and 22 November last year. The purpose of that was to ensure that the

inclusion of IJBs would have no significant wider impacts or unintended consequences under the Equality Act 2010, including the fairer Scotland duty. An equality impact assessment was undertaken, as was a fairer Scotland duty assessment. After considering all the responses to the consultation, the Scottish ministers concluded that there are no clear equality, operational or strategic planning barriers to progressing the proposal and legislating for the inclusion of IJBs within the Civil Contingencies Act 2004 as category 1 responders.

The inclusion of IJBs will ensure that formal, co-ordinated and appropriate arrangements are in place for emergency planning to support local communities. Members will be aware that the Delegated Powers and Law Reform Committee considered the technical, legal and drafting points of the proposed change and did not make any comments on the instrument.

I thank the committee for the opportunity to speak to the SSI. I am happy to take any questions that members might have.

The Convener: I invite members to indicate in the chat box if they have a question.

As the minister said, we considered the issue at our meeting on 17 June 2020 and wrote to the cabinet secretary on 25 June to seek confirmation that steps would be taken to alter the legal designation of health and social care partnerships. I take it that the measure meets in full the suggestions that the committee made to the cabinet secretary on 25 June.

Mairi Gougeon: Yes, that is right. Some concerns were raised through the consultation, but it is important to remember that the order will formalise an arrangement that should already be in practice. It is not expected that it will result in any additional burdens on IJBs, which is one of the concerns that was raised. As I said, it formalises the process and ensures that IJBs form part of any emergency response and are integral to the process.

The Convener: There are no further questions, so we move to agenda item 8, which is the formal debate on the order. I invite the minister to move motion S5M-23920.

Motion moved,

That the Health and Sport Committee recommends that the Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2021 [draft] be approved.—[*Mairi Gougeon*]

Motion agreed to.

The Convener: That concludes consideration of the instrument. We will report to the Parliament accordingly. I thank the minister for her attendance.

Budget Scrutiny 2021-22

11:36

The Convener: Agenda item 9 is consideration of the Scottish Government's budget for 2021-22. I welcome Jeane Freeman, the Cabinet Secretary for Health and Sport, and Richard McCallum, who is interim director of health finance and governance at the Scottish Government. Thank you for joining us.

On 10 November, the committee published its pre-budget report, "More than 50% of the Scottish Budget—What are the expected outcomes from the Health and Social Care 2021/22 Budget?". The purpose of the timing of the report was to provide the Government with time to consider the implementation of our recommendations in its forthcoming budget.

The Scottish Government response to our report was received just yesterday, which has limited the opportunity for members to consider it ahead of the meeting. Nonetheless, I am sure that the cabinet secretary will reflect on the response in her opening statement, after which we will move to questions.

The Cabinet Secretary for Health and Sport (Jeane Freeman): I am grateful for the opportunity to give evidence on the budget proposals for our health and care services.

As Kate Forbes said in Parliament, the 2021-22 budget is delivered in "exceptional circumstances" that require and have required an "exceptional response". The budget provides funding to support our urgent work to control the virus and to protect our health and care services and the people of Scotland while the vaccine is delivered as quickly and safely as possible. It provides funding to remobilise and reform health and care services, and to reduce health inequalities, which have been exacerbated by the pandemic.

To deliver that, spending on health and care services will exceed £16 billion for the first time, with a further £869 million allocated to support the on-going response to the pandemic. The funding settlement sees every penny of additional health resource consequentials passed on in full.

We will ensure that our front-line services have the funding that they need to respond to the unprecedented challenges that the virus continues to present, to remobilise and to recover, and to redesign services. Funding for front-line NHS boards will increase by £316 million, which is a 2.8 per cent increase. That builds on our record level of front-line health spending in Scotland, which is currently £112 per person and 4.8 per cent higher than the spend per person in England.

We have ensured that all NHS boards are within 0.8 per cent of their target funding share, which is the closest that boards have been to parity since the formula was established.

Our budget will deliver investment of £180 million to tackle waiting times, enabling boards to start to address the pandemic-induced backlog when it is safe to do so, and to improve access to hospital-based services.

The Scottish Government will increase its package of investment in social care and integration by a further £72.6 million, thereby underlining the commitment to support older people and people with long-term conditions, and recognising the vital role that unpaid carers play. That takes the total package of investment in health and social care integration to £883 million and supports our on-going commitment to move the balance of front-line spending to community health services.

Primary care is, of course, central to our health and care service, and plays a critical role in promoting self-care and supporting management of long-term conditions. In 2021-22, we will invest more than £1.9 billion in primary care. We will further increase our primary care fund from £195 million to £250 million, which includes support for delivery of the new general practitioner contract and for wider primary care reform to improve access and outcomes.

We will increase direct investment in mental health services to £139 million, taking overall spending on mental health to more than £1.1 billion. That funding will underpin our continued approach to improving mental health services and support for children, young people and adults and will support the delivery of the mental health transition and recovery plan, providing continued support for mental health assessment services and building on innovations and new service designs that have emerged in response to the pandemic. That includes the "Clear your head" campaign and continued expansion of digital services.

We will continue to invest in digital health and care to improve digital capabilities and digital access to care, to drive collaboration and innovation and to support self-care and digital inclusion. That will include continued expansion of the Near Me video consulting service, which is now being offered to all public service organisations in Scotland.

The budget further supports our work to tackle health inequalities and protect those who are most at risk. One of the greatest health inequalities that Scotland faces is the disproportionate harm that is caused by drugs and alcohol in some communities. The budget provides funding of £145.3 million for alcohol and drug services, including £50 million that is targeted towards reducing drug deaths. The funding will be directed through a wide range of partners in order to focus on reducing harms, promoting recovery and supporting our national mission to reduce drug deaths.

In 2021-22, the budget will continue to provide support to improve opportunities to participate, progress and achieve in sport and physical activity in order to improve physical and mental health, wellbeing and resilience. We will work with sportscotland to protect sports investment and we will continue to underwrite potential shortfalls in lottery funding, in line with previous years.

Capital investment in 2021-22 will increase by more than £100 million to £529 million. That investment in our infrastructure will support the delivery of the Baird family hospital and Aberdeen and north centre for haematology, oncology and radiotherapy—ANCHOR—as well as increasing elective capacity across Scotland to further support a reduction in waiting times. We will also provide additional resource funding to continue implementation of the Scottish trauma network.

The Scottish budget for 2021-22 takes investment in health and care services to more than £16 billion for the first time, in recognition of the immediate and long-term effects of Covid on physical and mental wellbeing and on health inequalities. We will protect front-line services, continue to shift the balance of care towards community health services and continue to provide investment for direct interventions to address health inequalities. I commend the budget to the committee.

The Convener: Thank you, cabinet secretary. As you said, in the coming financial year, there is significant additional funding that relates to Covid-19, as we would expect. However, if we set that aside, we see that the increase in the health resource budget is broadly in line with that in the wider Scottish budget, whereas in recent years it was slightly ahead. Does that reflect a shift in priorities on the part of the Scottish Government or just a balancing effect, given the additional Covid funding for the health budget?

11:45

Jeane Freeman: Excluding Covid-19, the increase to the overall Scottish Government block grant settlement is 2.9 per cent in cash terms. We are not shifting our priorities. Health resource consequentials have been passed on in full, and there is more, with additional funding for drugs—the £30 million—which takes the total increase to £730 million.

In addition, as you have rightly recognised, there are significant Covid consequentials amounting to £869 million. The Government's overall priority, in addition to those in other portfolios, remains that of providing significant investment in health, not only to respond to the demands of the current pandemic but, as I have tried to say and as I might have the opportunity to cover in response to the rest of the committee's questioning, to recognise that a number of areas of continuing investment have been initiated because of Covid and will need to continue. Testing and vaccination are two of those areas. We also need to invest in remobilisation and recovery of our health service as we, I hope, move out of the pandemic in the months ahead.

The Convener: The first part of the funding for Covid that has been provided in the current financial year was set out in some detail in the summer budget revision. However, there is still some detail to come, I think. There is not much detail in relation to the plans for the £869 million in Covid-related funding for the next financial year. Can you indicate what the priorities are for those allocations?

Jeane Freeman: I can. As I said, the costs of testing and test and protect, as we refer to it overall, will continue significantly throughout the coming financial year. On vaccination costs, generally speaking, we all agree that, although we do not yet know about the efficacy of the current vaccines in preventing transmission, the general expectation, which is sensible, is that our annual vaccination programme will be significantly greater in the coming year, and potentially the years thereafter, than the flu vaccination programme. We do not and cannot yet know the scale or size of it, but we need to retain the capacity to invest in the infrastructure.

NHS boards need to scale up or return to more normal working as we move out of the current situation. That requires boards to remobilise and to consider how they will catch up with the non-Covid health harms that are inevitably occurring.

Social care support is another key element of the priorities for the use of the consequential funding. As you know, we have already allocated funding in that area in the current financial year. We anticipate that we will continue to need to provide that support, and that includes support for additional personal protective equipment. As you know, we support social care with PPE and we will continue to do so. The overall cost of that might change, depending on infection prevention and control guidance, but those areas of expenditure are there. Given the many pressures on boards, we anticipate an underachievement of board savings.

All that will be informed by the third iteration of board remobilisation plans, which I expect to receive by the end of this month. We have specifically set out to consider the remobilisation of health and social care as one system, if you like, and the board plans will come to us by the end of February.

David Stewart: Cabinet secretary, will you explain and describe how Covid-related funding allocations are made for individual boards?

Jeane Freeman: I can do that briefly. Richard McCallum might want to add some details, since he undertakes and oversees that important work to ensure that we do it well. As I said, we are waiting to receive the third board remobilisation plans. The initial ones were produced in April and supported the immediate response; the second ones were produced at the end of July and mapped out a forecast for the rest of the year; the third remobilisation plans, which are due at the end of this month, will recognise anticipated costs for 2021-22.

The plans are subject to constant review and challenge. We then consider actual additional costs and allocate the funds on that basis. Richard will be able to give you a bit more detail about how that process works.

Richard McCallum (Scottish Government): I have two points to add to what the cabinet secretary has said. In allocating that funding, we have taken a hybrid approach that involves a mix between formula allocation and direct targeted funding. Where all boards have incurred similar levels of costs, we have allocated on a formula basis. However, we know that there have been particular pressures or costs in individual systems in some instances, and we have allocated accordingly where that has been the case.

We have worked closely with directors of finance throughout the pandemic. In the initial wave, we got weekly updates to understand the full cost implications that they were incurring so that we could undertake appropriate due diligence and governance at pace. We then moved those regular meetings to monthly ones. As the cabinet secretary has laid out, the detailed review with each board, through which we can assess, challenge and scrutinise costs, has allowed us to allocate the funding.

David Stewart: What financial lessons have been learned through the course of the pandemic? Have you found a need for more central planning, which Governments are always alleged to want, or has more devolution of decision making to boards been required? Alternatively, has it been a mixture of both?

Jeane Freeman: Again, Richard might want to say a bit more about that. We have conducted

almost continuous reviews of lessons learned across all the areas of the health portfolio, with boards, integration authorities and other key stakeholders, including our partners in local government. We are applying some of those lessons as we go.

It is a mixture of both approaches. When delivering a national response to a pandemic, it is important to be really clear about what we expect boards to do nationally and how they should operate. The clinical prioritisation framework, with which I know Mr Stewart is familiar, is clear that, in responding to more Covid cases with a finite resource of beds, staffing and so on in our health service, decisions need to be made about which services to slow down or perhaps pause completely. I know that members understand that.

We have been clear that urgent trauma and cancer care need to remain a priority throughout the pandemic. However, the framework allows boards to make their own decisions and gives them flexibility to respond to the varying levels of Covid demands that they face, while ensuring equity of approach across the country. Boards work within the clinical prioritisation framework to prioritise planned procedures in a particular way, while knowing that what is classified as a P4 procedure in one part of the country has exactly the same classification in another. We attempt to give flexibility so that boards can make quick decisions in response to the pandemic and to provide equity for patients across the country.

Richard might want to touch on other lessons with regard to overall financial planning and so on.

Richard McCallum: I will add three things. First, we have found real benefit in the whole-system approach, where local systems have not just viewed additional funds from an acute or health board perspective but looked at social care pressures and community care opportunities in the round. That whole-system approach is what integration is all about, but it has been strengthened through the pandemic. Where that approach has been taken, it has been key in terms of funding.

Secondly, to go back to Mr Stewart's previous question, although allocations can be done on a formula basis up to a point, during the pandemic, we have seen cases where the NRAC—NHS Scotland resource allocation committee—formula is not the most appropriate approach, so it might be worth reviewing NRAC to see whether there are other options for how we allocate.

Thirdly—I guess that I would say this as a director of finance—there is the on-going importance of governance. Although we have had to make quick decisions and be agile, nonetheless, we have had to bear in mind the value-for-money implications. The ability to balance the need to make quick decisions while testing value for money has come through in the pandemic.

David Stewart: I have a final question. What efficiencies have been identified as a result of the new way of working? Has that led to savings or has—[*Inaudible*.]—funding areas such as social care?

Jeane Freeman: Again, Richard McCallum might want to add to what I have to say. A number of efficiencies and improvements have been achieved. Examples of that would include staff working remotely, and increased use of telephone and video appointments for patients, when that is the right approach for clinicians to take.

It is interesting to touch briefly on the fact that, pre-pandemic, we had the Near Me video consulting facility, which was primarily used in NHS Highland and had very little uptake elsewhere. It is now used across the health system in many instances in primary care and is growing into other areas. A number of specialist consultant colleagues are also looking to use it for some of their out-patient facilities, and there has been really good feedback from clinicians and patients. Of course, it has to be a clinical decision about whether face-to-face consultation is needed, because digital does not replace face to face.

It is a bit early to quantify the position on savings. In our 2021-22 planning process, we will review those areas across the sector. I hope that we will see boards wanting to embed new ways of working because of their clinical impact and patient-centred approach, and also because they might produce efficiencies. Again, Richard McCallum might want to add to that.

The Convener: Before I call Richard McCallum, as part of that territory, does the Scottish Government plan continue to use community hubs?

Jeane Freeman: Thank you; that is an interesting question. As an innovation, community hubs were very quickly and rightly set up in response to the pandemic, and our thanks are due to all those, including primary care colleagues, who worked so quickly to set them up within three weeks. However, they and we can see a continued use for that type of approach in a non-pandemic health system. At the moment, we are thinking about how the community hub approach, the increase in out-of-hours coverage, minor injury units and the redesign of urgent care—which is under way—can work together to bring the right care as close as possible to the patient.

Richard McCallum: I will not add much to what the cabinet secretary said. In some ways, it is quite early to know the full extent of the benefits

that we might have seen through the use of digital and measures such as the redesign of urgent care. One of the key things that we will pick up with health boards through the remobilisation plans that the cabinet secretary talked about, which are due at the end of February, is to understand in more detail what opportunities the boards see in that space, and we will have those meetings with boards in March.

12:00

Sandra White: I will ask a couple of questions on medium-term financial planning and commitments. What impact has the pandemic had on the forecasts and assumptions that are set out in the medium-term health and social care financial framework?

Jeane Freeman: Until the end of 2019-20, the financial performance was broadly in line with the trajectories that we set out in the financial framework. It is still a bit too early to fully assess the impact of Covid-19 because, of course, we are still experiencing it, but we expect to see a greater shift in services for the community, and the performance and financial assumptions that underpin the financial framework will need to be revisited in due course. We have that work in our sights.

Sandra White: I am sorry about the video; the connection is not great here. Maybe it is good that you cannot see me, I do not know. I understand that reply and I thank the cabinet secretary for the paper that she sent to us last night, which included some answers to my questions, which I will reply to. My second question carries on from that; when does the Scottish Government plan to publish its update on the medium-term health and social care financial framework?

Jeane Freeman: Mr McCallum might want to say a bit more, because he will undertake that significant piece of work. Our current position is that we will review that as we move out of the current pandemic; it is very difficult at this point to confirm timings, and I will make sure that the committee is aware of that. As I have said, the financial performance assumptions that underpin the framework will need to be revisited. There will be a further iteration, but I cannot be certain when that might be because it will be determined in part by how swiftly we move out of the current pandemic state.

Richard McCallum: We made a number of assumptions in the financial framework, which the committee will be familiar with, about the levels of savings that we expected to make and the shift to community spending of more than 50 per cent during the current parliamentary session. All those things need to be reviewed and revisited in view of what has happened in the past year, because it has, in some instances, accelerated some of that shift and, as the cabinet secretary said, it will take time for that to be bedded down in the next year or so as we continue to work through the pandemic. From my perspective, we are committed to updating the financial framework and will keep the committee updated on that work.

The Convener: The cabinet secretary talked about some of the highlights in the capital investment strategy. Will a strategic document be published to set those out in more detail and are there plans to use revenue financing to fund future capital investment in health facilities?

Richard McCallum: I will answer the question about the capital investment strategy first. Last week, the Cabinet Secretary for Finance published an update of the infrastructure investment plan, which informs capital funding for all portfolios over the next few years. That will inform the capital investment plans for the health and sport portfolio, and we will be using it as the basis for our strategy and plans.

On the question about revenue financing models, there are no plans to use revenue finance in any of the schemes or capital programmes that we have under way that the cabinet secretary mentioned at the start, such as the Baird and ANCHOR in Aberdeen and the elective centres. The Government is considering whether the mutual investment model, which is a revenue financing scheme, could be used in the future. As I say, however, there are no plans for any current capital spend in health to use that model.

Donald Cameron (Highlands and Islands) (Con): My questions are about national health service board budgets. NHS territorial boards appear to be receiving a much smaller cash increase than in recent years—1.8 per cent compared to 6.3 per cent last year. Can the cabinet secretary explain why there is a lower increase this year?

Jeane Freeman: It is important to say a number of things. First, when we take into account the additional funding for primary care, mental health, trauma networks and drug policy, the uplift is actually 2.8 per cent. Health boards have significant responsibility for all those. We cannot think about health boards exclusively in terms of acute and hospital-based care. There is also the additional Covid funding.

The uplift does not take account of the agenda for change pay negotiations that require to be undertaken as we move into the 2021-22 financial year. As Mr Cameron will know, we are in year 3 of a three-year agenda for change pay deal that affects a significant number of staff. We have very consciously said that, in addition to the current

board allocations, the Scottish Government will fund in full whatever is the outcome of those negotiations. We need to acknowledge that that is additional funding that will go to the boards.

The other point that I would make is that last year, about 3 per cent of the uplift to boards was in recognition of an increase in pension costs. That was a new spending demand on boards, but it is now part of the recurrent funding and that additional 3 per cent is now in the baseline.

If we take all that together, we are looking at an uplift of 2.8 per cent against, broadly speaking, 3.3 per cent last year. However, this year we have still to add in the funding requirement, whatever it is, for the negotiated agenda for change pay deal.

Donald Cameron: Will the three health boards that are receiving on-going financial support be required to repay that funding? What is the general prospect for those boards? For example, do you expect them to break even within the next three years?

Jeane Freeman: Again, Mr McCallum might want to add to what I am about to say. Boards will not be required to repay any funding received in 2021.

It is still too early to say whether boards will continue to require in-year financial support and whether they are likely to break even within three years, although things are not where we want them to be. We need to revisit that through the remobilisation plans and the additional financial scrutiny that we will be doing. We will be clearer on that as we move out of the pandemic and see what the boards are planning and as a result of how we scrutinise, challenge and approve those plans. We will then understand more clearly the financial position of all the boards and, on that basis, what we think is a fair position to take with them and a fair expectation to have of them.

Richard McCallum: In 2020-21, there will be no repayment of the funding that has been provided in this financial year, in recognition of the fact that all boards have required significant additional funding for understandable reasons related to Covid. As the cabinet secretary said, working with those three boards, we are keen to understand the full impact of what has happened in the past year and what that means for their trajectories. Undoubtedly, it will have had an impact—it will probably have an impact on the financial plans of all boards, and that will be picked up with the boards. Given the nature of the non-recurring funding for Covid, it might take a year to understand that fully, but we will work closely with the boards on it in the next few months.

Donald Cameron: My final question about the long-term issue of the NRAC funding formula was touched on in answers to a question from David Stewart. Do you consider that NRAC remains the best way to allocate resources, given that a number of funding streams are not allocated using NRAC?

Jeane Freeman: That is an important question. I am on record in the committee as saying that all formulas have their advantages and disadvantages and that it is pretty difficult, if not impossible, to devise an entirely fair formula that produces no disadvantages. That said, Mr Cameron makes an important point. The NRAC formula should be reviewed, partly in light of the pandemic but perhaps also in view of the review of adult social care led by Derek Feeley, the report of which was published last week, as members will be aware.

As Mr McCallum said, the process of looking at the system in the round—how it has worked during the pandemic and how we are planning as we move into the next financial year—must be underpinned by reconsideration of the basis on which funds are allocated and the need for that to be a whole-system approach. The NRAC formula needs to be reviewed in light of all that, and a different formula or approach might need to be adopted as a consequence of the review. At this point, the safest or the fairest thing to say is that, yes, it should be reviewed.

The Convener: The boards that have received brokerage will be pleased by what they have heard today. Mr McCallum said that there is an understanding of the pressures on all boards, and that, therefore, there will be no pressure for repayment and the process of achieving a break-even position will take time. Looking at it from the point of view of other boards, the question might be: what incentive is there to achieve a balanced budget, given that you could be described as taking a forgiving approach to those boards that have not achieved a balanced budget?

Jeane Freeman: Convener, I am very rarely described as taking a forgiving approach, so I hope that somebody has put that on the record. All boards understand that they will face difficult situations at different times and that the approach should be fair to the system overall. That is the approach that we are taking.

12:15

We recognise that, not just for the boards that you mentioned but for all boards, achieving savings in the current financial year has been an exceptionally difficult ask, not least because all boards' resources and energy have gone into responding to the pandemic. That is about not just the number of cases and people in intensive care units but, for example, the need to set up community hubs, contribute to the testing and

vaccination programmes and do all the other vital things that had to be done. As we come to the end of this financial year and have discussions about the mobilisation plans for the next year, into that mix will go consideration of what is a reasonable expectation of overall board performance, including the performance of the boards to which you referred, and what timeframe we should be looking at. We will ensure that the future cabinet secretary and health and sport committee are fully apprised of whatever conclusions we come to. At this point, however, it is not possible to give a more definitive answer—I do not know whether Mr McCallum wants to add anything.

Richard McCallum: I will add two things. First, on the point about 2020-21, we have recognised that this has been an exceptional year, given the additional funding pressures—as well as many other pressures—on boards. We had to take that into account in our expectations on savings and the delivery of financial plans, and I think that it was right that we did that.

Secondly, there remains a statutory obligation on boards to break even. Our having had to recognise the challenges of this year—and potentially 2021-22 and beyond—does not mean that boards do not still have a responsibility to deliver financial plans that are achievable and can get them to the financial targets that they have set. We have to hold these things in balance, recognising the pressures that boards have faced while, as we move on from the pandemic over the next few years, recognising that there will need to be a focus on financial management and control as well as on service and quality. It is important that we do not lose sight of that.

George Adam: Cabinet secretary, there is always a challenge to do with how set-aside budgets operate when it comes to integration authorities. What steps are being taken to address the continuing concerns about that? Can lessons be learned from IAs that are doing well when it comes to the effective operation of set-aside budgets?

Jeane Freeman: Before the pandemic, quite a lot of work was under way to look at set-aside budgets and their operation with individual partnerships where that was a particular issue, such as the Fife partnership. All that work had to be slowed down—and, arguably, halted—for a number of months while people, including the partnerships, responded to the pandemic.

There are two factors that need to be considered as we move into the next financial year. The first is—Mr McCallum made this point and I completely agree with him—that the experience of the pandemic has seen significantly greater integrated working in practice on the ground, with proper joint decision making and an understanding of the contributions that different parts of the health and social care system make and the value of those contributions. There has been significantly greater learning in the past year than we had managed to achieve before that. It is unfortunate that it takes a pandemic to do it, but it takes everyone having to point in the one direction and work together to resolve matters and make decisions about the appropriate use of funds and so on.

Hold that thought for one moment, then recognise that we also have the independent review of adult social care, which sets out a number of recommendations and challenges. As we move into the next financial year, we are likely to see a different set of funding arrangements for that integrated service than those we have been used to. That may well, in and of itself, resolve some of the issues around set-aside budgets and the difficulties that were experienced in some IJBs and partnerships but not, as Mr Adams rightly said, in others. Pre-pandemic, we were using the lessons of those other IJBs to help us with those that were experiencing more difficulty, much of which was around understanding different parts of the system. The system as a whole has moved on considerably in the course of the past year.

George Adam: It is interesting that you mention the independent review of adult care in Scotland. It recommended that the budgets of integration authorities should be determined centrally. What do you think about that?

Jeane Freeman: As Derek Feeley himself said, the review looked at what it thought needed to happen to get the practice of integration aligned with world-class legislation on integration and at what, if any, change had to be made to the architecture around that. His conclusion is that there should be a national care service that should be directly accountable to ministers, who should be directly accountable for it. The route of delivery that he identifies is through integration joint boards. That significantly alters their role and therefore the resourcing goes direct to them. I completely understand the logic of his thinking.

I have already said in response to the review that we welcome it and that the current Government is content with all the recommendations. As, I suspect, Mr Adam knows, a week today we will have a Government debate in the Parliament on the independent review. Of course, given the timing—next week is the middle of February and the Parliament will stop towards the end of March for a Scottish Parliament election—a great deal of pick-up on the review will be for a future Government. Nonetheless, we can take some steps in advance of all that to lay the foundations for the national care service and the

particular person-centred approach that Derek Feeley advocates.

George Adam: That was my final question, convener.

The Convener: Does Richard McCallum have anything to add to the cabinet secretary's points on integration authorities?

Richard McCallum: I will add one point in relation to set-aside budgets. A number of case studies in the response that came back to the committee show areas of good practice. Updates from Lothian, Grampian and Lanarkshire, as well as from Dumfries and Galloway, set out some of the improvements and changes that there have been in relation to set-aside work over the past year.

The Convener: Brian Whittle has a supplementary question on the topic.

Brian Whittle: I was listening very carefully to your answers to George Adam about the IJBs' response to the pandemic. Based on what my constituents are reporting to me, I suggest that the pandemic has raised significant issues around two different systems working without proper communication with each other.

Does the cabinet secretary agree that the incredible pressures that have been put on the IJB system have highlighted, and given you the opportunity to understand, where the real pressure points are and where the problems lie? Will the Government take cognisance of that, and what will it do to close the gaps in the system? We all agree that those who are working in the system have done an incredible job under incredible pressures, but the integration of the two systems has not worked as well as we had hoped that it would. What lessons can be learned?

Jeane Freeman: Some, if not all, of Mr Whittle's constituents are also mine. If I am completely frank, I am struggling a bit to answer his question, because I am not getting any specifics. In general, yes, all systems should be reviewed, lessons should be learned and, if there are gaps, they should be filled. However, until he tells me what they are, I do not know what specific concerns Mr Whittle is referencing.

Brian Whittle: Cabinet secretary, you do. You have been through sessions such as this one several times. The fact is that the NHS system that looks after those who are transitioning from home care to hospital care and back again has been extremely problematic. Those systems have to be reviewed, because they are not working as well as you seem to be intimating. That is not a criticism of those who are working in the system—the system itself is not working as well as it should be, considering the amount of time that we have been working with IJBs. I am asking whether the Government will take cognisance of the issues and look to close the gaps?

Jeane Freeman: That is helpful. I disagree that it is the system that is not working, although all systems should always be improved and open to improvement.

In many of our IJBs and partnerships, support is provided to people who are living independently in their own homes or are in residential care, and that support is realigned to suit what they need, with them as the central part of the conversation, when they move into hospital or are discharged. Such support exists in some IJBs and partnerships and works well in parts of the country. The Feeley report recognises that, and uses some of those good examples, some of which are in my constituency. However, that is not consistently the case across the country, and Mr Whittle is absolutely correct about that.

Work on the matter has been going on for some time, and continues to focus on those partnerships and IJBs that are doing less well than we would expect, because, when someone is admitted to hospital for hospital care, we are not seeing an approach that involves forward planning to the person's discharge date and focusing on them as a person and the help that they need to continue to live as independently as they wish. That work is under way, and it will continue throughout the rest of this parliamentary term, and undoubtedly inform part of the future Government's response to the Feeley report.

The Convener: Thank you, cabinet secretary. We may resume this evidence session on a future occasion. We have been able to ask, and get answers to, many important questions, but there are other areas that members wish to explore in some detail. If you are content for me to do so, I will conclude the session for now, but invite you to return to resume questions at a future date.

Jeane Freeman: Of course.

The Convener: Thank you. In that case, the meeting will move into private session.

12:29

Meeting continued in private until 12:34.

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