OFFICIAL REPORT
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Health and Sport Committee

Tuesday 26 January 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 26 January 2021

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HEALTH AND SPORT COMMITTEE

3rd 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:

James Anderson (Scottish Trauma Network)
Dr Michael Donald (Scottish Trauma Network)
Edward Dunstan (Scottish Trauma Network)
Mairi Gougeon (Minister for Public Health and Sport)
Peter Lindle (Scottish Trauma Network)
Michael Matheson (Cabinet Secretary for Transport, Infrastructure and Connectivity)
Dr Martin McKechnie (Scottish Trauma Network)
Geoff Ogle (Food Standards Scotland)

Euan Page (Scottish Government)
Dr Iain Wallace (Scottish Trauma Network)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 26 January 2021

[The Convener opened the meeting at 10:00]

Scottish Trauma Network

The Convener (Lewis Macdonald): Good morning and welcome to the third meeting in 2021 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton. I ask all witnesses and members to ensure that, during the meeting, mobile phones are in silent mode and notifications are turned off.

The first item on the agenda is a one-off evidence session on the Scottish Trauma Network. I welcome to the committee Dr Martin McKechnie, who is national clinical lead of the Scottish Trauma Network; James Anderson, who is lead clinician at the north of Scotland trauma network; Michael Donald, who is lead clinician at the east of Scotland trauma network; Edward Dunstan, who is lead clinician at the south-east of Scotland trauma network; Dr Iain Wallace, who is interim lead clinician at the west of Scotland trauma network; and Peter Lindle, who is a consultant paramedic in major trauma at the Scottish Ambulance Service. I thank our witnesses for joining us and for the comprehensive report and information that they provided to the committee in advance of the meeting.

We move straight to questions. I will start with a question for Martin McKechnie, and I will then invite members, in turn, to ask additional questions. If witnesses wish to respond or to contribute to the discussion and I have not called them to speak, I ask them to indicate that they wish to be called.

I want to look back to the origins of the trauma network. I refer to the geospatial optimisation of systems of trauma care—GEOS—study, which was published in 2015. The study suggested that major trauma centres should be set up in Glasgow and Edinburgh only, but Aberdeen and Dundee have led the way and are where trauma centres are now up and running. Does that mean that the GEOS report got it wrong in all important respects?

Dr Martin McKechnie (Scottish Trauma Network): No, it does not mean that the report got it wrong. A lot of decisions were made based on the GEOS study, which were then reviewed. Committee members will know about the processes that took place before the political decision to set up the four major trauma centres was announced. I note that many of the people on my team who are attending today's meeting, including me, were appointed subsequently.

Decisions were made before the trauma network was set up to carry out work on the conclusions of the clinical academic GEOS study and to implement the political decisions about where trauma centres and units would be located. There were many considerations regarding place, such as the movement of patients around the country at the time and, perhaps, the infrastructure that was available in Scotland at the time. We in the trauma network have tried to make progress by creating the network and enabling far more cross-boundary working.

Some of the major factors involved in translating the GEOS study into clinical practice are geography, weather and distance. Scotland is very interesting—almost unique in the world—in terms of its population distribution and concentrations, as well as its remote, rural and island communities.

We have set high standards to get optimal trauma care to patients at the roadside and all the way through their care pathway into rehabilitation, which is a new approach to trauma care. It has not been done before anywhere in the world to the same extent that we are doing it. That might sound bullish and ambitious, but it is important.

Trauma centres are located where they are to try to create a system of multiple specialties. That has translated into a multispecialty system, by which I mean that trauma centres were not previously joined up in the way that we are trying to achieve now. We are doing that by collaborating across territorial, geographical and specialty boundaries, which did not happen before. The GEOS study has presented us with information about what happens, where it happens and how it happens, and the trauma network has taken that on to provide the best care, whether in an urban centre or a remote and rural area.

It is an on-going moving battlefield. I would not be surprised if there were changes in the future in relation to where services are located and how they are delivered. Certainly, in the past three years of our involvement in delivering trauma care in Scotland, things have changed markedly. The GEOS study was an important leading study. We are presented with four major trauma centres; it is our ambition to deliver the final pieces of that jigsaw in the next few months.

The Convener: That was an interesting answer. In a sense, you are saying that, rather than there being a fault in what was originally proposed, you have gone well beyond that and are working across boundaries in a way that was perhaps not envisaged five or six years ago.

Given that major trauma centres are at the pinnacle of the structure as originally envisaged and indeed as delivered, will the coming on stream of two further major trauma centres in Glasgow and Edinburgh affect the throughput of patients in the existing centres in Aberdeen and Dundee? Will that have any impact on the expertise available in the major trauma centres in Aberdeen and Dundee?

Dr McKechnie: The answer is yes and no. I will explain. We have a relatively small number of major trauma patients every year in Scotland. If we talk about trauma in its entirety, we are talking about several thousand—say, 6,000—patients. Severe injury may account for up to 1,500 of those patients. Those are incredibly complex cases—they are what we call multisystem cases, which can involve a head injury as well as a neck or chest injury and so on. Such specialist care requires lots of areas of surgical and clinical expertise, if we are to deliver the optimal patient care and rehabilitation that we want to deliver for those patients.

That is an on-going and long-term benefit to Scottish society, and it is therefore right that we invest heavily up front in trying to deal with those patients as quickly as possible and as closely as possible to the location of their accident or injury. That is why the trauma centres are spread out across the country. Again, I go back to geography. In the past couple of years, we have had extremes of meteorology and climate difficulties. That is part of the thinking behind placing hospitals, as well as trauma centres and services, where they are. If you wish, we can go on to that in greater detail in due course.

In answer to your question, I say that a small number of patients will necessarily be taken from trauma units, which are a step down from major trauma centres but are still well equipped to deal with most trauma injury. The most serious stuff goes to the major trauma centres. On occasion, there may be a requirement for certain multitrauma or polytrauma patients to be moved from one trauma centre to another. That would be the case for significant injuries that need neurosurgery, paediatric care, burns care or what we call orthoplastic care, which is a combination of orthopaedics and plastic and reconstructive surgery. By necessity, such services might be based in only one hospital in Scotland.

If I am in Aberdeen, for example, and I have a surgical issue that requires transfer from the initial reception at the Aberdeen royal infirmary, I might need to go to another centre for on-going burns care. We almost saw that in August last year, when the train crash happened on the line from Aberdeen to Glasgow. Luckily, there were only a few people on the train. Sadly, there were deaths, but it could have been a whole lot worse. Part of the planning for that was about making sure that we were able to transfer and transport certain types of patients across regional and health board boundaries to the place where they would get the best, quickest and most optimal treatment, based on their injuries. I hope that that answers your question.

The Convener: It does, absolutely.

The other aspect I wonder about is whether there is an optimal number of patients and throughput that is appropriate for maintaining skills and expertise in major trauma centres. If so, how does that compare with the numbers that you described?

Dr McKechnie: There is an optimal number, and the centres that we have available will deal with those optimal numbers.

A lot of the answer to the other part of that question will be based on data that comes out in the coming years. It will not be easy to tell that story right away.

In years gone by, we have perhaps not had the completeness of information to allow us to benchmark that in as detailed a way as we would always have liked. However, that is because of the complexity of individual patients' distribution of injury and the patterns of care that are required to be delivered in areas outwith their regional home territory and the area of reception of the patients' local trauma centres and units.

Therefore, the answer to your question will come in some years, when we get a full reflection of the data and the network is fully up and running. I hope you appreciate that although, behind the scenes, we are ready to be activated as a national trauma network, one or two pieces of that jigsaw are still to be completed.

Doing that has been slightly scuppered during the past year, because of additional pressures that we all know about. Those are caused by difficulties in staff redeployment, recruitment and demands made upon health services.

I think that that story will come out, but we are already on the right path. We have some unpublished data. I cannot share that with you at the moment, but it will come quickly once the trauma network is fully established and running.

The Convener: Thank you. We will move on to the next question, which is on the same theme, from Sandra White.

Sandra White (Glasgow Kelvin) (SNP): Good morning, gentlemen. Following on from the convener's questions, I have two of my own to ask. They relate to the Glasgow and Edinburgh trauma centres, which are not yet operational.

As constituency MSP for Glasgow Kelvin, I am particularly interested in the situation in Glasgow. Initial recommendations were that Aberdeen and Dundee open trauma centres—I note the fact that there is a lot of cross-boundary working, as the witness mentioned—and that Glasgow and Edinburgh's centres were to be operational in 2021.

Last night, the committee received a letter from the Cabinet Secretary for Health and Sport. If you could bear with me, I will read a couple of paragraphs from that letter to you all. In her letter, the cabinet secretary mentions that

"The committee will be aware, both Major Trauma Centres ... in the West and South East have yet to be officially opened"

and that

"While both the West and South East continue to treat and care for trauma patients through existing pathways, the expectation was that"

they would go live and be

"supported by the Trauma Triage Tool by the end of 2020/21".

However, as has been mentioned by Dr McKechnie, there have been

"ongoing pressures"

in relation to Covid. There is also the issue of training.

I note that the submission from the Scottish Trauma Network says that in Dundee, at Ninewells hospital, one of the trauma wards had to be turned into a Covid high-dependency unit. Therefore, I see that Covid is having an effect in Dundee, also.

The cabinet secretary's letter also said:

"While both areas can be reverted back to their original purpose, it would be retracting critical COVID-19 capacity and as a result applying further pressures to other parts of the service."

Do you agree with the cabinet secretary's explanation as to why the trauma centres are not open yet in Glasgow and Edinburgh? If you want to raise any other issues in regard to that, I would be pleased to hear them.

Also, has the delay in opening centres in Edinburgh and Glasgow had any effect on the trauma cases in Aberdeen and Dundee and has it had any effect on trauma care in the west and south-east of the country?

The Convener: We will go first to Iain Wallace, who is interim lead clinician in the west of Scotland.

10:15

Dr Iain Wallace (Scottish Trauma Network): First, it is disappointing that we have not been able to open as planned, in March. However, I think that everyone understands the reasons for that, and the cabinet secretary has laid that out in the letter.

We hope to keep on top of all of this, and we are ready to go. As soon as things appear to be under control, we will begin the process of opening the centres. It has been quite a challenging time, because of Covid. Staff have been moved to deal with Covid cases.

I think that establishing the major trauma centre ward at the Queen Elizabeth university hospital is difficult, given the situation, because, at the moment, as has been mentioned, it is a high-dependency area for medical patients. However, we are, in many respects, ready to go. Some capital build changes have been a bit delayed, as have some appointments—that is, being able to put people in place—again, because of Covid. However, most of it is there.

I also assure you that in the west, we are working as a network anyway, as are colleagues across Scotland. People are meeting and discussing cases. We have a monthly clinical governance meeting at which we discuss cases. Our aim is to improve the quality of care, even without the opening of a major trauma centre. Things have moved along at quite a pace and are better than they were a few years ago, even though we have not yet got the MTC opened.

The Convener: We go to Edward Dunstan, from the south-east of Scotland.

Edward Dunstan (Scottish Trauma Network): We in the south-east are also very disappointed that we are unable to open, but I assure every member of the committee that we have made very significant progress over the past four years when it comes to dealing with major trauma patients. Iain Wallace has talked about the robust clinical governance processes that are in place. We have morbidity and mortality meetings; we have standardised paperwork; and we still adhere to the key performance indicators, which you may well hear more about later. There is also a lot of shared learning. Each region produces its own newsletters. We feed off each other. We have regular clinical and non-clinical meetings.

We have appointed a very large number of staff to support the process. For instance, at the Royal infirmary of Edinburgh, we have appointed six emergency care consultants, which means that there is now 24/7 senior doctor front-door coverage . We never had that before.

To open as a major trauma centre, we need to attain some minimum requirements. As Iain Wallace has already talked about, one of those is having a major trauma ward. That is where all critically injured patients go, are cohorted together

and cared for and looked after by appropriately trained, skilled and supported members of the healthcare team, such as physiotherapists, pain specialists, psychologists, nurses, and doctors across a whole ream of specialties. Before the major trauma network was even considered, such patients were scattered around the hospital. They might be on a general surgery ward, an orthopaedic ward or a medical ward, but now we need to put them into one area where we have appropriate skills and expertise.

Unfortunately, the proposed major trauma ward at the Royal infirmary of Edinburgh is a Covid assessment area, which would be an inappropriate place for such critically injured patients. As Iain Wallace has already mentioned, we have managed to proceed despite the Covid pandemic. The team has worked so hard. We have still managed to appoint to all the necessary positions so, from a staffing point of view, we were ready to go in March.

We have had to completely change the way we have done education and training. It has all gone online—all our morbidity and mortality meetings are online now—but it still works. We did not have that in 2017. Major trauma cases are still being dealt with in a much better way than they were in 2017.

However, you are absolutely right. Any delay to opening will be to the detriment of major trauma care. There is no getting away from that. However, I can assure you that, in our region, we are still doing everything possible to make sure that individual patients are treated effectively. People might think that, because of the Covid pandemic, people are not driving cars and there is not so much major trauma around, but that is not the case. We have hardly seen a fall-off. People are injuring themselves in different ways, such as, more recently, by tobogganing.

It is disappointing, but there is no question in my mind that we will open this year. The team is ready to go.

Sandra White: I thank the witnesses and all the staff for the good work that they are doing.

Peter Lindle might want to talk about the trauma triage tool, which was to have come in for the Ambulance Service but is not yet operational in the west or the east—is that correct?

Peter Lindle (Scottish Trauma Network): That is correct. Our front-line staff will use the triage tool to make decisions about where best to take patients for care, whether it be a local emergency hospital, a trauma unit or a trauma centre. We cannot start using it until all the trauma centres are open and are an option to us, which is why it has not gone live in the west or the south-east yet.

Emma Harper (South Scotland) (SNP): I am interested in how Covid has affected trauma. The submission from the Scottish Trauma Network says:

> "Trauma has continued throughout the pandemic, with some changes in presentations and changes in numbers during periods of lockdown, clinicians across the country continue to respond to trauma calls alongside management of Covid patients,"

I would assume that certain types of trauma, such as that resulting from road traffic accidents, reduce during lockdown. I am therefore interested in whether the witnesses think that the number of major trauma cases remains largely unchanged while other types of trauma were affected by the restrictions.

I remind everybody of my prior experience as an operating room trauma nurse in Los Angeles. I am interested in how Covid has affected trauma and the types of trauma in Scotland.

The Convener: I will ask James Anderson from the north of Scotland network to respond to that.

James Anderson (Scottish Trauma Network): I agree with the earlier comments and with Martin McKechnie's comments. In the north, the number of major trauma admissions has continued largely unchanged in absolute terms, but it is the type of case that has changed. Because people were spending more time at home during the first lockdown, we saw more injuries in domestic settings, such as falls from height, or falls during domestic tasks. Unfortunately, the clinical impression is also of an increase in injuries related to alcohol and, to a degree, self-harm, which I suspect is an indication of levels of distress that some people are experiencing.

Road traffic accidents are still occurring. Again, this is my clinical impression rather than the numbers—it is difficult to be sure statistically—but my impression from the network is that accidents involving multiple people have dropped a bit because people are travelling individually rather than with multiple occupancy in a car.

During the current lockdown, general trauma has still seen some road traffic accidents and, of course, in the north of Scotland, with ice and necessary travel because of geography, we are still seeing on-going admissions.

Emma Harper: I assume that there have been some challenges during the pandemic with engaging and managing the network. NHS Dumfries and Galloway had issues with slips and trips and fractures because of the weather and, obviously, that had an impact on its ability to manage Covid numbers. What have some of the challenge been during the pandemic?

James Anderson: With Covid in general, there have been ward and staff pressures from having to reorganise within the hospital. As is stated in our report, there has been a degree of cross-support to the intensive care unit and the high-dependency unit as needed, as well as the slips, trips and falls aspect, which has added a little bit of pressure on the accident and emergency side, too.

Dr McKechnie: It has been shown in recent submissions of data to the Scottish trauma network that very major trauma has increased, interestingly. There has been the status quo or a slight reduction in what we would call less severe trauma, and the reasons for that are behaviourally interesting. Clearly, we have been in various degrees of lockdown over recent months, but there is evidence showing that severe trauma from road traffic accidents and leisure-related activities has increased.

Other areas where there has been an increase include, sadly, domestic violence and mental health-related self-inflicted violence and violence against others. Within that melange, or pudding, of trauma patients, we are seeing patterns developing, and major trauma has increased during the pandemic. Shielding or elderly patients are perhaps not out and about quite as much as they were before, and levels among those groups have remained static or slightly less. There has been a changing demographic there.

I suggest that Peter Lindle may wish to come in on that, given the pre-hospital aspects of transferring and treatment at the roadside.

Peter Lindle: We are still seeing a lot of slips, trips and falls, especially given the weather over the past few weeks, and the investment from the trauma network has really been helping us to deal with those cases better, despite the fact that we do not have the full network running yet.

For example, we can now give antibiotics to people with open fractures. That is a new thing for the Ambulance Service, and it has been evidenced to improve outcomes for patients. We have better splinting. We have advanced practitioners who can now go out and look after complicated fractures better so that, when patients go into the emergency department, they are already adequately analgesed, reduced and packaged, which makes the job of the ED a bit easier. Those things are happening now, thanks to the investment that we have put in, despite the fact that we are not fully operational yet.

Dr Wallace: I will make a further small point about Covid and the investment that has already been made in major trauma centres. Regional anaesthesia allows for the avoidance of general anaesthesia for people with limb injuries. Certainly in the west, we have been able to invest a bit in that, so there is now 24/7 availability of it. That reduces the need for general anaesthesia, which is a risk factor in terms of Covid and staff. That is a further benefit.

Emma Harper: I was going to ask Peter Lindle to talk about new ways of working—he has described some of them already. It is important to hear about pre-hospital treatment, or treatment in advance, so that we can help to achieve better outcomes for patients. I would be interested to hear any expansion on new ways of working.

I have a final question on what was described by Edward Dunstan. He mentioned that people feed off one another in the trauma network and learn from one another. Are we learning from other places that have rural challenges such as Canada, Alaska or Australia, which has a rural health commissioner, and working with them to see how they manage things?

10:30

The Convener: That question might be ideally suited for James Anderson to kick off with. I also want to hear from Michael Donald in the east network.

James Anderson: Yes, we have some links with other countries. We have been considering the preliminary results of some projects with one of the Australian groups that did a lot of remote—[*Inaudible*.]—and one of our consultants in Raigmore worked remotely in Australia as well. We also had a visit from a group from Norway. We try to learn from other people's experiences, but I also feel quietly proud that we lead the way a little bit, as Martin McKechnie said previously, by creating the network in the geography of the north of Scotland.

Despite Covid, the need for flexibility and, as Edward Dunstan mentioned, the degree to which things have been done virtually, we have really tried with the investment of the network to push for continued contact with the people for whom we care, irrespective of geography, for both pre-hospital treatment—again, I would always defer to Peter Lindle on that—and discharge at the other end.

Dr Donald: I rewind to address one of the points that Emma Harper has raised, which is relevant to her prior experience of work in the operating theatre environment. The challenge that Covid has presented to us in running a major trauma service—this is equally relevant to Peter Lindle's Ambulance Service colleagues—is the requirement for adequate protective personal equipment for the major trauma team that now assembles to manage the patients at the front door of the hospital. The additional complexities of

having to don aerosol-generating procedure PPE to receive patients who will require critical care intervention have produced a significant strain on the system that we had developed.

Prior to the inception of the major trauma service, many of those critical patients were managed by just an A and E team, who would then contact specialist colleagues in the hospital to deal with them, depending on their injury load. In the east of Scotland, we have now assembled a multidisciplinary team that will be available at the front door of the hospital to manage those patients. As trauma team leaders, we have had to be creative in our management of the numbers of staff who receive the patients at the front door, in order to protect the team and provide its members with adequate PPE. That has been one of the significant effects of Covid, particularly in the first wave, in which we elected to reduce the number of individuals in aerosol-generating procedure PPE to receive the patients initially.

We have learned a lot from that initial lockdown, which has allowed us to get back to a point at which we can wrap all the necessary specialists around that major trauma patient safely and continue to deliver seamless care, from the roadside to rehabilitation, while protecting our staff. That point is relevant to Emma's experience in the theatre environment and to how important it is that the team feels safe in the environment that it works in.

On the second point about remote and rural medicine, I did trauma management work on a rescue helicopter about 15 years ago in New South Wales in Australia. Australasians were 20 years ahead of the UK at that time in relation to major trauma management. I am pleased to say that the developments in Scotland now surpass what has for many years been available to the public in Australasia. There is a high-level care system there, but it is very much devolved to regions. There is not a huge amount of cross-pollination at the borders of New South Wales and Queensland, whereas the network in Scotland has been developed across all geopolitical boundaries.

Wherever in Scotland someone ends up experiencing major trauma, the network assumes responsibility for that patient and works hard to wrap care around them. That cannot be said for the entirety of Australia and New Zealand. In Scotland, we can be proud that we are moving close to that, and it will be the outcome by—I hope—the end of the year.

Dr McKechnie: In response to Emma Harper's questions, I was going to suggest that Michael Donald should say what he has just said. I am glad that he has spoken about that and I will not go back to it. His international experience and his reflections on what has happened here are telling and important.

To extend what Michael Donald said and address Emma Harper's point about international learning—I am getting a lot of echo, so I ask the committee to forgive me if I sound stilted—I note that we have had visits from teams from Norway, given presentations at meetings in New Zealand and Denmark and had visits and queries about how we are setting things up from governmental and healthcare organisations in Qatar and Philadelphia. I suggest that—surprisingly—the balance of information flow is in the opposite direction, which goes along with what Michael Donald said. People are asking us how we are doing this, which is important for the network's kudos and prestige and for how it has been set up.

Edward Dunstan: I will be brief, as a lot of what I was going to say has been mentioned. I give the absolute reassurance that there is a huge amount of shared learning. All the trauma units and major trauma centres have their own morbidity and mortality meetings at which difficult cases are discussed. We have regional meetings at which we discuss such cases in more depth and national meetings at which we do so again. We produce quality improvement newsletters that contain shared learning points about what could have been done better and what went particularly well.

As with other regions, those from the south-east have visited trauma centres in Nottingham and St George's hospital. Working in major trauma centres outwith Scotland is still part of the job contract of some colleagues in the south-east. There is a flow to and from places.

Before Covid, Martin McKechnie and the team set up excellent national days every year when we heard from guest speakers from all parts of the world. They gave us top tips, quick wins and low-hanging fruit to pick so that we could change patient care.

I give the absolute reassurance that there is a huge amount of shared learning. Our regional and national clinical governance structures, which did not exist before, have made a huge difference.

Peter Lindle: I will answer a bit of one of Emma Harper's questions. The changes that are taking place in pre-hospital care are detailed in our submission. We have three levels of response to major trauma patients.

To answer another question, the key thing that we learned from Australasian models was that clinical co-ordination of the assets is needed. To get past the geographical boundaries and the challenges of working round mountains and lochs, we need someone who is at the centre of everything to ensure that the limited resources are directed to the patients who need them most.

The key point that we learned from other parts of the world was that we need someone in our control centres to point the assets at the right people. That is why we have invested heavily in the trauma desk model of clinical co-ordination.

As a paramedic, the big change for me is that, through the network and the relationships that we have built with the people who are on this call today, for the first time, we are receiving feedback on our performance in looking after our trauma patients. That has been a massive change, and those relationships, which we did not have before, are what will bring about big improvements in pre-hospital trauma care.

Donald Cameron (Highlands and Islands) (Con): Good morning to all the witnesses. Many of my questions about pre-hospital care and the main changes have already been answered. How is the standard of pre-hospital care assessed? How do you grade it, as it were?

Peter Lindle: As Martin McKechnie said at the start, ultimately, we will grade the quality of the pre-hospital care that we have delivered on the basis of the feedback from the major trauma centres and through the relationships that we have with them. When we bring patients in, there are expectations about how they will have been looked after—[*Inaudible*.]—and which medications they will have been given. If that care has not met the required standard, we will hear of that through our various governance meetings and feedback from our colleagues in the major trauma centres. We have our own suites of internal measures, which are in their infancy. However, in trauma care, identifying the things that can potentially kill our patients and treating those as quickly and effectively as we can are the most important factors for us.

From evidence, we know that we tend to lose people in pre-hospital scenarios because of things such as bleeding, chest injuries and major head injuries. A great deal of the investment that we have made in trauma care, particularly at the green level—the paramedic level—has been in equipment and medications that can address those issues. Those include better splints and tourniquets to stop bleeding and pre-hospital medical teams that can give patients blood at the side of the road, which is a completely new thing. We also have advanced practitioners, who can give adequate analgesics to trauma patients, over and above what we could give before. Chest injuries can now be addressed at the side of the road by performing surgical procedures that previously could have been provided only in an emergency department.

As I said, to answer your question, we measure the effectiveness of pre-hospital care on the basis of feedback from our colleagues in major trauma centres. That is why the idea of the network is so important—because that is how we will gauge the effectiveness of our work.

I hope that that answers the question.

The Convener: Yes. I will bring in Edward Dunstan now.

Edward Dunstan: The Scottish Ambulance Service is an absolutely key part of our family—our team. There is a representative of it at every regional clinical governance meeting. It has warning about the patients who are chosen to be discussed, and we are able to go through a patient's journey, all the way from the first 999 call. Sometimes we even listen to the recordings of those phone calls in the meetings, and we are able to support and offer peer review of the decisions that were made. For example, we look at whether the patient was transferred to the major trauma centre—[*Inaudible*.]—by land or by air and whether they bypassed the local trauma unit. Everything is broken down into time slots. We are able to offer peer support and critique to see whether anything could have been done better. If there are things that could have been changed, we share the learning points through our quality improvement newsletters, which we share across the region and discuss nationally. The role of the Scottish Ambulance Service is critical. We support each other, and there is critique when it is required.

James Anderson: On the point about pre-hospital care and the changes and improvements with the Scottish Ambulance Service through the network, the feedback from the remote and rural hospitals and the local emergency hospitals is that the creation of a single-point-of-contact critical care desk with the ability to reach expertise and support for what are still relatively infrequent events in some rural places has been revolutionary. A number of senior clinicians on the islands and in places such as Caithness have spoken highly of the changes. They used to make many phone calls to arrange care and seek advice, but there is now a network, so they have one point to contact. That has been a huge benefit to pre-hospital care and the initial staging into hospitals.

10:45

Dr McKechnie: I will take Donald Cameron's question a bit further. In addition to the governance aspect that you have heard about from Peter Lindle and Edward Dunstan, it is important to understand that the Scottish trauma audit group absolutely scrutinises us—in fact, it sometimes feels as though we are being persecuted by it—in relation to improving and assuring our quality. STAG feeds into the network

externally and looks at patients who stay in hospital for three nights or more as a result of trauma.

We are trying to extend that remit into general information governance. We have appointed an information manager to consider trauma information from other areas, such as the Department for Work and Pensions, the Crown Office and Procurator Fiscal Service, the police and fire services, and the Crown Office if the matter crosses borders into England and beyond. To answer your specific question, we are trying to get all the data in order to get the whole picture.

To take the point a bit further, you will have seen links in our submission to both STAG and the trauma app. We are developing the app to get a much higher standard of recording, safety governance, quality improvement and quality assurance. All those things coming together will create a far more robust structure of governance and safety for patients, and provide for the quality-assured performance of the staff of all constituent parts of the network.

Evidence suggests that, if we do well all the things that Peter Lindle and Edward Dunstan described, we are probably looking at a 30 to 40 per cent reduction in deaths in hospital. By that, I mean that, if we improve the pre-hospital care, by the time they get to their definitive care in the trauma unit, the major trauma centre, or even the local emergency hospital, a third or more of the patients who previously would have died will not die. Accompanying that is an expected reduction in the length of hospital stays. The bang for buck here—which is important to me and, I am sure, to you—is based on improving the clinical care that is provided from the minutes after the accident or injury.

Dr Wallace: STAG has been great. The clinicians are really involved in the data and looking for improvement.

The culture of the network is very supportive. There is constructive challenge, which is good. It is about working together—without the network, that would not exist—and there is a focus on quality improvement.

Donald Cameron: Thank you for those comprehensive answers.

I want to ask about transfer times. We know that trauma systems work to an optimum transfer time threshold of about 45 minutes. This may seem to be an obvious question, but how important is it to get patients to a trauma unit within 45 minutes, and what proportion of patients have been transferred in that time?

Peter Lindle: The evidence around the timing of 45 minutes is not particularly strong. You will have seen that some of the English networks have recently expanded that to 60 minutes. I guess that that is our starting point. We will be looking to use the network to assess whether that time limit is correct, and maybe to extend it, as has been done down south.

On your question about how many people have been transferred within the time, I would need to look at that and come back to you on it, if that is all right. I am happy to submit some data on that to the committee's clerk.

Donald Cameron: My final question is also about transfer times. We know that 14 per cent of the Scottish population are outwith the 45-minute threshold for transfer to an MTC and that 7 per cent of the population are unable to reach an MTC or a trauma unit within 45 minutes by road. Many of us on the committee represent rural communities that may be particularly affected by that. What is being done to mitigate the effect of longer transfer times on people who are unable to reach a unit or an MTC within 45 minutes?

Peter Lindle: We acknowledge the challenge of having such a large part of the population living on islands and in remote communities. To address those challenges, we have put together our Scottish specialist transport and retrieval service—ScotSTAR—teams. You will be aware of those teams—we have just put in a new one as part of the work of the trauma network in the north of Scotland. The idea is that, when someone cannot make it to a major trauma centre or trauma unit within the ideal timeframe, we can use one of our ScotSTAR consultant-led retrieval teams to bring the emergency department to them. We can provide a lot of the interventions that people would expect to get in the first few minutes of arriving at a major trauma centre by sending one of those teams out to the patient by helicopter or fixed-wing aircraft. Whether the patient is in a district general hospital on an island or even at a remote general practice, we can send out those consultant-led teams, and effectively take the care to the patient. That makes use of the air assets that we are very lucky to have in Scotland. We can use our two funded air ambulances, which our charity ambulance colleagues support us with, and our fixed-wing aircraft to cut down the timeframe.

I mentioned clinical co-ordination. We identify people who need that type of help as quickly as possible by having clinicians listening to 999 calls as they arrive and ensuring that the assets that we have at our disposal are tasked as quickly as possible, which minimises the delay in getting patients to where they need to be.

Dr McKechnie: Peter Lindle has said pretty much what I was going to say, but I will add a little to that.

We took a conscious decision in the core group, which was ratified by our network steering group, not to go to 60 minutes. We challenged ourselves to deliver the 45-minute standard. That is currently being measured. The data is unpublished, but we will report on that in due course, once the network is fully established.

Mr Cameron's point is well made. We bring the expertise to the patient. A development in that sense has been ScotSTAR north, which has involved collaboration with Scotland's Charity Air Ambulance. We now have fixed-wing and rotary assets based in the north at Aberdeen airport, which we did not have before. We also have the augmented pre-hospital immediate care team—PICT—at Raigmore hospital in Inverness, which has a range and a capability for a lot of roadside accidents up in Mr Cameron's neck of the woods. With support from the trauma desk and the ScotSTAR teams, we aim to deliver care in that critical time window when we know that the most severe injuries cause the most damage unless they are managed immediately.

We have collaborated in our pre-hospital group with the British Association for Immediate Care Scotland—BASICS—service of advanced trained general practitioners in remote and rural communities and the Sandpiper Trust. They are part of our on-going education system to deliver augmented roadside care until we either transfer the patient to the appropriate facility or the red team comes to the patient.

The Convener: For certainty, you said that a decision was reached to stick with the 45-minute target rather than changing it to 60 minutes. I take it that that was made on clinical grounds.

Dr McKechnie: It was taken on clinical grounds, but it was based on perhaps more urban environments. We see that as a lever to improve pre-hospital care across the whole of Scotland. The job that we have been tasked with is to deliver equity of care, whether a person is in Orkney, Dumfries, Stornoway, the Borders or the urban central belt.

Edward Dunstan: Martin McKechnie got it on the nose. It is about equity of care. No matter where a person lives in Scotland, they should have access to exactly the same resources that someone else has access to. In the south-east, we are an urban trauma network, which means that the vast majority of our patients are within a 45-minute reach. However, I reassure the committee that not only major trauma centres have minimum requirements; the trauma units do, as well. The trauma units can still supply a significantly high level of care for critically injured patients if that is required. That has required investment in staffing and training in the trauma units.

For instance, a minimum requirement in a trauma unit is that there must be the ability to open the chest of a critically injured patient. Essentially, that is extremist life-saving surgery. Those skills have been disseminated. There is a minimum requirement for the nursing and the doctors, the seniority of doctors, and the time that key specialists need in order to get to the emergency department. It is about networks and not just the major trauma centre, and it is about upskilling the trauma units in case they have to deal with those patients.

We have also worked very hard nationally on hot transfers. It has to be remembered that up to 20 per cent of people who are critically injured will self-present to a hospital or a trauma unit and will not be picked up by the Scottish Ambulance Service. We have worked hard nationally on protocols on how to get those patients, who might be unstable in an ED, to go from ED to ED. The committee heard earlier on from James Anderson, I think, that, previously, a person would have to pick up the phone and call a lot of different people in different specialties to get the patient accepted. That is not the case when the network goes live. There is a single point of contact. If a trauma unit calls a major trauma centre, there will be no denying of that patient being transferred. The patient will be put in an ambulance with the appropriate staff, and they will get to the major trauma centre in a timely manner. I reassure members that our trauma units are also very capable of dealing with major trauma patients.

James Anderson: Much has already been said. Through our governance process, a couple of incidents have been identified of late in which it was crucial that either the red team or PICT was able to triage on scene and make those—[*Inaudible*.] In those cases, that had a direct impact on survival.

David Torrance (Kirkcaldy) (SNP): My questions are on triage, although some of them have been answered.

A key role of the Scottish Ambulance Service is to triage patients to the most appropriate hospital for their needs. The service is guided in those decisions by the major trauma triage tool. Are the triage decisions and the MTTT subject to any kind of audit or evaluation? I know that STAG has been mentioned, but I would like to hear more on that issue from the panel members.

Peter Lindle: We have the major trauma triage tool, which is based on and similar to other tools that are used around the globe. When the tool goes live, our paramedics document the decisions that they have made using it on our electronic patient report forms in the backs of ambulances. Once paramedics have made a decision, they key in how they made it by choosing exactly which

trigger caused them to make that choice of destination. All the data is collected electronically and shared with STAG. The tool has already gone live in some regions and, as soon as it goes live in the other regions, we will be collecting that data.

Of course, we will look at whether the tool is sensitive enough—whether it over-triages or under-triages patients too often—and, as has been said, the trauma network will meet to tweak it accordingly. That is absolutely our intent.

11:00

David Torrance: Have the changes to triage improved patient outcomes? I know that that was mentioned earlier, but will somebody expand on it?

Peter Lindle: That would be for the STAG data to tell us. The triage tool has been live for a while in the north and east of Scotland networks. In those networks, because the geographical distances between hospitals are so large, a 45-minute triage does not make a huge amount of difference in where the patient will end up. Of all the regions, the west of Scotland network is where we will see the biggest difference in the places to which patients are triaged. We need to wait to see the impact of that through the STAG data and to see whether triage is making a big difference in patient outcomes.

Other panel members might want to come in on that.

Dr McKechnie: The answer to David Torrance's question is not yet—we cannot yet prove results, because the network is not fully live, but there is strong evidence from our overlapping clinical governance set-ups. By that I mean the Scottish trauma network clinical governance structure, the Scottish trauma audit group structure, and the trauma desk at the Scottish Ambulance Service and its clinical governance structures. We all overlap, feed into one another and learn.

There is some evidence that the processes and the times to treatment, times to computed tomography scan for head injury, and times to assessment and administration of, for example, anti-bleeding or anti-infection drugs are having an effect on patient care. However, the long-term results from traumatic injury are, by their nature, long term. We will see increased survival, but we are looking for the quality of that survival. At the risk of sounding brutal, I point out that a lot of trauma patients are young, and it is in the best interests of society that we rehabilitate and resuscitate them to the maximum so that they become functioning members of society again.

The bang for the buck in the long term remains to be proven, but I think that it will be. However, there is clear evidence that it takes about five years for that information to really begin to feed through so, if we are allowed to reconvene in five years, we could probably tell you the full story. I hope that, over the next few years, we will begin to see upward trends.

The Convener: That sounds like the term of the next session of Parliament.

Brian Whittle (South Scotland) (Con): I want to push a little further on outcomes, because the trauma centres were created in the hope of saving additional lives. The STAG report shows mortality for trauma patients and estimates that, in four of the last seven years, the number of survivors has been lower than the predicted number of survivors. How reliable is the analysis of mortality, and should we be concerned by those findings?

Dr McKechnie: It is reliable in the context of what STAG reports, which relates to patients who spend three days or more in hospital as a result of traumatic injury. Earlier, I alluded to the fact that there is an area of governance that has never really been explored, or has not been joined up, I should say. I am referring to people who die at scenes and people who die very quickly after traumatic injury. There is information on that from the Procurator Fiscal Service, the police and other public bodies. We have formed initial links and relationships with those bodies and, in years to come, we hope to be able to report about how those gaps were filled and perhaps give a more robust structure for the answer that Mr Whittle seeks.

The evidence from our governance structures so far is that early interventions are improving patient care and that the training and education that we are putting in place are augmenting that.

Brian Whittle: If I could summarise the point, I was saying that you might be able to analyse the data to examine the factors that might be impeding survival and perhaps to explain away the initial STAG report findings. Do you have access to that kind of data?

Dr McKechnie: As I said, we have access to some of that information. Additional information will come as our information probing extends. Part of that is because the information manager who we have appointed will have access to data across public health, STAG data and Government data. The picture will become clearer.

The other aspect is that the governance structures that we set up are increasingly mature and refined, and I hope that that will translate into easily publishable data. However, it takes some time—until we come to the end of each patient's journey—to prove that it was, in fact, effective.

Edward Dunstan: To return to a previous question, the trauma triage tool is absolutely evidence based, and we took a long time picking useful bits from other major trauma systems. With the English model, it was probably five to eight years before robust improvement could be demonstrated in care in England.

As Martin McKechnie has discussed, it is not just about survivability—that is not what we are dealing with; it is a whole different picture. We are dealing with reducing disability and reducing the economic and social burden to the individual, the individual's family and society. A lot of that is about reducing psychosocial impairments. I have talked about reducing family disruption and addiction, and about an early return to work. You must remember that only 36 per cent of critically injured people with major trauma return to their normal place of work within six months. That is why rehabilitation—which is a massive part of the project—is key.

You need to think about the reduction in tax revenue that is caused by major trauma, and the change in benefit uptake from reducing major trauma. By putting all these systems in place, we should absolutely be able to show not just the physical and psychological benefits but the financial benefits of dealing with those patients in a scientific and evidence-based manner.

One thing that we never did previously in the south-east was gather patient-recorded outcome measures, or PROMs, which concern the physical and non-physical wellbeing of an individual. As part of our key performance indicators, PROMs now have to be gathered and presented, and they will come in through the STAG audit.

We now have a major trauma co-ordinator in all of our regions. They are a first point of contact for all our patients who are injured. Those individuals follow up patients not just in a hospital setting but after they have been discharged, ensuring that they have access to appropriate pain clinics, physiotherapy, rehabilitation and all those sorts of things.

The things that have been done have been a game changer—it is like night and day. The changes that we have seen since 2017 have been extraordinary and I assure you that they are to the benefit of the population of Scotland.

The Convener: I am conscious of the time, so let us move on.

David Stewart (Highlands and Islands) (Lab): I wish to move on to consider key performance indicators. How do you evaluate the results of each KPI, and how do you remedy poor performance?

Dr McKechnie: [*Inaudible*.]—by scrutiny across the various bodies that are involved in the trauma network. We do it through the governance structures that I have described, with STAG as a crucial part of that.

If poor performance is identified via those sources, it is my job to address that. However, I am happy to say that the integrity of all the people who work in the network means that I have not yet had to wield any of that soft power, because any deviation from an accepted standard or benchmark that comes out of the scrutiny or poor performance via the governance structures is automatically and swiftly dealt with at regional level. That is the answer to your question. The system is internally governed, but with scrutiny from external structures that overlap with every aspect of the trauma network's function.

David Stewart: Thank you for that answer. I got most of it, although you were muted just at the start, unfortunately. I got the drift of your answer, however.

If my reading of the results are correct, performance improved across the board between 2018 and 2019, with one exception regarding computed tomography scans and, specifically, the time to undergo a head CT scan. Why was that?

Dr McKechnie: Basically, we had parameters that were not practical. The structures around CT scanning required a lot of external input from the radiology services and from reporting systems, as well as the availability of scanners. Under our embedded KPIs, we want to get people into a CT scanner within a very short time of their arriving at an emergency department. Not every department was set up in a way that allowed that to happen but, through various measures and collaborations with the radiology managed clinical networks as well as through STAG, we have been able to refine those parameters and to review some of the criteria, based on clinical evidence, that mandate CT scanning of the head at various points in the patient's journey.

Part of that involves a collaboration between us and our colleagues in radiology—by which I mean X-ray and CT reporting. A lot of new investment has taken effect in the world of radiology, and that is now bearing fruit in the management of trauma patients. It is easy to get quick CT in major trauma centres and in lots of trauma units, but it is not so easy sometimes in the more remote hospitals. However, a lot of reporting and investment in radiography staff has since taken place, and the information is coming to us much more quickly, which will ultimately be to the benefit of the patient, based on a neurosurgical decision for the treatment of their head injury, for example.

David Stewart: That was very clear. I can fully understand that. For the 2020 KPI, which you compare with 2019, are you changing the goalposts in what you analyse, or are you keeping the same measure? If so, do you hope to improve the 2020 KPI compared with the 2019 one?

Dr McKechnie: I would use the term "refining" rather than "changing the goalposts". I know that you will appreciate that terminology.

The analysis is based on clinical evidence. I have alluded to the pressure that my senior team and I perhaps put on the network not to drop our standards but to strive to achieve the highest and best standards. I am not surprised that there have been some dips in performance—I expected that. I also expected the rebound improvement in performance that is now coming through.

11:15

David Stewart: I am conscious of the constraints on our time, convener, so I will go to my last question, which is on an issue that might have been touched on earlier. Has there been any significant increase in trauma from self-harm since the start of the pandemic?

The Convener: That has been mentioned by one or two of the witnesses. Does anyone in particular want to respond?

Dr McKechnie: The answer is yes, there has been. A lot of that is lockdown or pandemic related. People have struggled and, unfortunately, we have seen a lot of serious violent self-harm and harm to others. I would not say that that was unpredicted, but it is a new feature of some of the cases that we have been seeing during the past year.

Treating those patients' physical injuries has been part of the trauma network's remit. However, as James Anderson, who is a clinical psychologist, would state, the on-going aftercare and rehabilitation of the patient is much improved.

The Convener: That is very good to know.

I am conscious of the time. I have not been able to call some witnesses to respond, so I will be directing one or two questions to witnesses after the event.

George Adam will ask our final questions of this session.

George Adam (Paisley) (SNP): I was interested in Edward Dunstan's point about the trauma co-ordinator's role being a "game changer". I agree, having read about that. As has been said, rehabilitation is a long process. A patient being seen by a trauma co-ordinator within three days of their stay at hospital and creating a rehabilitation plan for them while they are in hospital and for when they are at home is obviously the way forward.

I have two brief questions. How well received have the co-ordinators been by patients, who, at the end of the day, are the most important people? Could such a role be used for other services?

The Convener: Perhaps James Anderson would like to comment on those questions.

James Anderson: I will again do so quickly, convener. The short answer is that the trauma co-ordinator roles have been very well received.

The experience of major trauma for the patient and their family is extraordinarily complex. There are an enormous number of systems and specialties, and having one or two people who you can contact, who your family know and who will speak to you when you are discharged is hugely useful in finding a way back into the systems. That single point of contact for the patient, which in a way reflects Peter Lindle's point about the ambulance service, has been useful and well received.

I think that the role has utility for other conditions in which multiple specialties are involved, and we have had interest in it as a model.

The Convener: Excellent. I thank all our witnesses for that comprehensive introduction to and report on the work of the trauma network and centres across Scotland. There are a number of matters on which the witnesses offered further information following the session, and there will be other questions that we will want to explore further in writing. We will seek your co-operation in that.

Thank you very much for attending. We look forward to a future report to Parliament on further development of the network, as Martin McKechnie described.

Provisional Common Framework on Food and Feed Safety and Hygiene

11:19

The Convener: The next item of business is an evidence session on the provisional UK common framework on food and feed safety and hygiene. As we know from last week's meeting, the common frameworks are being developed to ensure that rules and regulations in given policy areas remain consistent across the UK, following our exit from the European Union. Our role is to scrutinise the common frameworks that fall within the committee's remit.

As we did last week, we have heard from stakeholders. We are also keen to hear from the Government, so I am pleased to welcome, for the first time in her new role, Mairi Gougeon, Minister for Public Health and Sport. She is accompanied by Euan Page, head of UK frameworks in the constitution and UK relations division of the Scottish Government, and, from Food Standards Scotland, Geoff Ogle, chief executive, and Jennifer Howie, UK frameworks and intergovernmental relations lead. We look forward to hearing from the witnesses.

The minister will make a brief opening statement about the framework.

The Minister for Public Health and Sport (Mairi Gougeon): I look forward to working with committee members in my new role. Thank you for inviting me to assist in deliberations on the provisional common framework for food and feed safety and hygiene.

Officials from Food Standards Scotland have been involved throughout the process, alongside officials from the UK's Food Standards Agency. As the committee is aware, the framework is one of a number of provisional common frameworks that will come before the Parliament and is part of a programme that my colleague, the Cabinet Secretary for the Constitution, Europe and External Affairs, has co-ordinated for our interest. I am therefore supported today by officials from FSS and the Scottish Government.

The development of the framework has been a collaborative effort, demonstrating genuine co-operation and engagement between UK administrations. Although provisional arrangements are in place and are now live, a formal agreement to the framework would ensure that those functions previously undertaken at an EU level are delivered coherently and robustly. It would signal a formal commitment from each of the UK administrations to work together to deliver shared objectives.

The committee has asked why it is seeing the framework only now, and why it is not alongside other frameworks relating to food. That is a consequence both of the approach by consensus that we have agreed with colleagues across the UK and of wider pressures, not least the current pandemic. I assure the committee that the framework will not be finalised until all UK legislatures have had an opportunity to consider it in full.

Nevertheless, excellent progress has been made on the framework. It is one of the first to go before the Parliament for scrutiny and it will ensure that repatriated EU functions relating to general and specific hygiene and safety requirements for food and feed products and businesses will be delivered to a high standard.

The framework has followed agreed protocols for framework development and includes agreed UK processes for making policy recommendations to ministers, as well as governance and dispute resolution arrangements. It has been developed in accordance with the principles of the joint ministerial committee for European negotiations, which were agreed by the Scottish, Welsh and UK Governments in 2017, and which the Northern Ireland Executive endorsed after its re-establishment last year. They include the principle that UK frameworks should ensure the functioning of the UK internal market while also acknowledging policy divergence, and that they should respect the devolution settlements and the democratic accountability of the devolved legislatures. On that basis, we consider that the framework delivers against the principles that were agreed in 2017.

I hope that the committee found my reply to its letter of 22 December helpful in answering some initial questions. I am happy to answer further questions.

The Convener: Thank you. We have a number of questions arising from our previous evidence session. Your December letter was helpful. I start by quoting Professor Paul Haggarty, a witness whom we have heard from on a couple of frameworks. His concern was that although

> "The ... mechanisms in relation to food and feed safety regulation, enforcement, etc, have developed organically over decades ... It is possible that the UK may fail to maintain those standards inadvertently by failing to appreciate the full complexity of the process".

Would you agree with that concern? Is it something that we need to be vigilant about? What is your view on how those complicated and interconnected standards can be maintained?

Mairi Gougeon: I can absolutely appreciate that concern. Professor Haggarty is right that it is a very complex process. However, it is not brand new to our regulators—Geoff Ogle may want to come in after me. It is a complex area, but bodies such as FSS and the FSA have been dealing with it for a number of years. Things may have developed organically over a number of years, but it is the job of our regulators to be on top of it all, which they have been throughout the process. I have every confidence in them as we move forward and do not doubt for a minute that they appreciate the complexity in how the process operates. The committee will be aware of the complexity of the process that we have just been through, because of all the statutory instruments and Scottish statutory instruments that you have had to scrutinise, which the Government has also had to do.

We have retained EU law in full, which obviously required a line-by-line analysis of food and feed law. As a result of that, I would say that we are all a lot more familiar with those requirements now that we have left the EU. However, I come back to the point that, although the process may be complex, I have confidence that that complexity is appreciated in the framework that we have established. Our regulators have been dealing with it for a long time and they are more than capable of dealing with it as we move forward.

Geoff Ogle (Food Standards Scotland): I agree with what the minister has said. Organisationally, we have recognised the impact of Brexit and increased our resourcing to deal with its consequences. The issue around international relations and ensuring that we maintain and work through those will be important. We have been doing that since we started. It will be important to work with the Scottish Government's office in Brussels in keeping pace.

We also have bilateral relationships with other member states such as Ireland. I will be talking to the chief executive of the Food Safety Authority of Ireland later this week. The need to keep an eye on what is happening with EU law is not lost on us and we have set ourselves up so that we can do that.

As for the complexities of the policy, as the minister said, that is not new to us. We have been dealing with EU law for some time and the conversion process. Ninety-five per cent of food law was EU law and we have managed to translate all of that, so I am confident that we have the capacity, capability and experience that we need.

Sandra White: As a wee follow-on, I have two questions. I was interested to hear that you have been following EU law and that there is some form of dialogue. We heard from witnesses last week who suggested that the European Union and the European Food Safety Authority should be consulted on the framework, and on related frameworks. Is any further dialogue taking place with the EU and the EFSA?

11:30

Mairi Gougeon: I appreciate that point, which I know was raised in evidence heard by the committee. I am not sure that consultation with EU institutions would be entirely appropriate in relation to how best to manage intra-UK liaison and policy. Of course, it is only right and fair that the Administrations should determine how the framework operates, and we would look to explore all possible avenues for maintaining that dialogue with the EU and its agencies.

We know that the UK will be sighted on any opinions that EFSA publishes. It is likely that, in respect of policy considerations that impact on this framework area and many others, the UK-EU joint committee on Northern Ireland will be key to the process.

More generally, the EU will form its own view on the effectiveness of the new arrangements within the UK for managing food safety. The UK will, as a third country, be part of an audit process; that is standard practice and will inform another avenue of direct engagement with the Commission in due course.

Sandra White: You mentioned the framework and how the UK will be involved. Going for consultation would need to involve the four nations, but we now know that it would be only three nations because Northern Ireland, under the protocol, is not involved in that particular issue. If the committee were to push for, or advise, speaking to the EU and EFSA in August, would that need to go through the UK framework, or could individual Governments or states take it forward themselves?

Mairi Gougeon: Sorry—[*Inaudible*.]—in terms of consultation or how we would engage in specific—[*Inaudible*.]

Sandra White: If the Scottish and Welsh Governments—Northern Ireland would be a separate matter—were to decide that they would like to consult with the EU and EFSA, would we be able to do that as individual states or countries? Could Scotland, Wales and Northern Ireland do that if they wanted to, or would that need to involve the four nations of the UK?

Mairi Gougeon: Northern Ireland is part of the framework agreement as well. That is what is important about the framework—it is essential that we have an opportunity for the four nations to come together as equals to discuss these issues.

There is a memorandum of understanding between the FSS and the FSA, and there are already a lot of close working relationships in place. The framework builds on and develops those existing relationships.

With regard to our engagement, we have our own Brussels office and we are looking to continue to engage and maximise all opportunities in that regard. I do not know whether the point that you were trying to get at was whether we are able to do that off our own back or whether we would need permission, essentially, from the other countries first.

Sandra White: Yes—I was asking whether each individual country could engage in consultation themselves, or if it would have to be done jointly.

Geoff Ogle: I will come in to offer some clarity. The answer is that both can happen. We have undertaken international engagement with EFSA, for example, jointly with Wales and Northern Ireland, and we have also had discussions on our own. Legally, we are the competent authority for food and feed safety in Scotland, and we are able to talk about those issues that are particular to Scotland.

On reserved issues such as trade, it gets slightly more complex, but I take the view that we can talk to Administrations or organisations such as EFSA either in our own right or jointly with the FSA. As I said, we have done both. It depends on the issue and the nature of the inquiry, and who is best placed to discuss it.

Sandra White: That clarifies some aspects of my last question.

We have talked about the common framework and how it works. Do you believe that the common framework and the new post-Brexit regime offer an adequate balance between risk assessment and risk management? I am talking about novel foods, genetically modified organisms and pesticides that are coming forward—in England there has been consultation about pesticides. I am concerned that all those things could sneak through if we do not have risk assessments and adequate balance. What is the minister's opinion on that matter?

Mairi Gougeon: The arrangements that we have agreed will ensure that that balance is there. I know that the framework will not cover pesticides, but I emphasise that exiting the EU does not impact on the fundamental principles of policy making in that area. Scientific evidence and other factors will continue to inform the policy as part of the risk analysis process and all the processes that applied when the UK was required to consider its position in relation to the development of EU policy as a member state.

The letter that I sent to the committee in response to the questions that it had sent in December includes links to various papers that FSS—which is responsible for the provision of policy advice to ministers on the matters that that framework area covers—has looked at in its board meetings. The letter also includes the detailed consideration of the risk analysis process, which comprises risk assessment, risk management and communication on those processes. I go back to the beginning of my answer to this question: the arrangements that we have set in place through this framework mean that the right balance is there.

Donald Cameron: Good morning to the minister and her officials. We have described the new landscape of regulation, the common framework and the post-Brexit regime. My first question is general: how might all the issues that could arise from the new landscape impact on innovation in our food and drink sector? Secondly, do you foresee any consequences for human health?

Mairi Gougeon: The overriding interest in the matter is the protection of public health, and the focus on that protection is the key element for all of us. We obviously do not want to see an impact on innovation in the food and drink sector, but it is clear, in the situation that we now face, that businesses will have to adapt to the added friction with which leaving the EU has presented us.

For many businesses, that adaptation might include direct investment in the EU rather than at home in order to continue to export to the EU market, because of added pressures due to the increase in bureaucracy as a result of our leaving the EU. It was reported the other day that that is what the Department for International Trade has advised businesses to do.

We are concerned about the impacts that those changes have on the food and drink sector and on our ability to innovate. In relation to the arrangements in the framework, the situation outlines how officials and ministers across the UK will liaise on a lot of the matters that are in the framework's scope. The new landscape, in and of itself, should not directly affect innovation, but the very nature of the fact that we have left the EU and the added burden of bureaucracy could have one of the biggest impacts on it.

Emma Harper: I am interested in interoperability of the framework with Ireland and the Northern Ireland protocol. Do you have any concerns on that point?

Mairi Gougeon: Yes, there are some concerns, but as I said in responses to the previous questions, the framework is a four-nations agreement. It is intended that we have as

consistent an approach as possible between the four nations. However, it is also designed to help and acknowledges that the devolved Administrations should have the right to consider what is in the best interests of the countries that they represent, and to build on that policy divergence.

It is clear that changes to EU law will require to be considered through the framework process, given that EU law will apply in Northern Ireland. The Scottish Government has already set out our view that law in Scotland should be aligned with EU law; we want to do that as far as is possible, where it is in our best interests. The framework arrangement means that it is inevitable that changes to EU law require to be considered in a UK context. We will have to monitor that very closely, too, as we progress through the coming months.

Emma Harper: Thank you for that, minister. Geoff Ogle said that FSA and FSS and EFSA all work well together anyway, because relationships have been built over the years. You mentioned divergence, which is also interesting to me. Divergence has always been recognised as being legitimate, where an Administration can show legitimate cause. In its response to the committee, the Scottish Government said:

> "Due to the relative size of production bases, this will mean that food law will be determined across the UK as a whole in no small part by the administration with the biggest sectoral interest."

Will that have an impact on Scottish producers if our market is smaller than the wider English or UK-wide market?

Mairi Gougeon: Emma Harper has raised an important point. As I said in response to the previous question, we have already set out our view that, as far as possible and where it is appropriate, the law in Scotland should be aligned with EU law. In relation to the possibility for divergence within the framework, Scotland might find itself in a better place with regard to providing necessary assurances to, for example, auditors. Ultimately, however, that would be a matter for the EU alone to determine.

I have talked about the frameworks allowing the four nations to build on existing relationships with agencies that we had worked closely with throughout the process, and to work together as equal partners. The biggest threat to all that is the UK Internal Market Act 2020. As members of the EU, when it came to mutual recognition the principles of subsidiarity and proportionality allowed for divergence, and had respect for devolved policy making. The act could undermine the good work that we could have achieved through the establishment of frameworks.

Emma Harper: I have a final question. On many occasions, I have raised in the chamber and in the Rural Economy and Connectivity Committee issues in relation to how we support the best produce coming into the country, and how we ensure divergence on the safety of food, which is a key issue for me.

I have mentioned the Food and Drug Administration in America having the "Food Defect Levels Handbook", which says that levels of contaminants that we would not normally find acceptable in our food supply chain are acceptable in the USA. Will the common framework be part of keeping an eye on that, or part of how we scrutinise future trade deals, given that levels of defects that are acceptable in some countries are not acceptable in the UK?

The Convener: If other witnesses wish to support the minister with comments, they should type "R" in the chat box.

11:45

Mairi Gougeon: Again, Emma Harper has raised an important point that plays into concerns that we have about whether what is laid out in the United Kingdom Internal Market Act 2020 means that we could be forced to accept goods that have been produced to standards that we would not necessarily accept. That is an approach that, again, completely undermines the framework process in which we have engaged in good faith, and which built on existing positive relationships.

The internal market act also legislates for problems that do not exist. In all the engagement that we have had with the UK Government over the past four years, not one area was identified as a problem that the act would address. In many ways, therefore, we do not see the need for the internal market act, which undermines work that we have done in good faith.

In addition to that, I note that the act is not a good piece of law. Emma Harper mentioned a specific example; I will give another example of what the framework would cover. The market access principles in the internal market act mean that a food additive that had not been authorised in Scotland, but which had been authorised in England, could not be sold here. If the additive was added to bread here, that bread would not have been produced in accordance with local law. Although the additive could therefore be sold and added to bread here, we would not be able to sell that bread in Scotland. However, if the bread was made in England using that additive, it could then be sold in Scotland. Likewise, a Scottish manufacturer could sell the bread that they make back to England. I highlight that example to show the complexity in the internal market act, and how

it is not good law because we will have such complex problems to deal with. The example highlights just one area in which we could see problems developing.

David Stewart: I, too, welcome the minister to the committee and to her new post, and I wish our witnesses a good morning.

I have only one question—about pre-market approvals and reauthorisations. The minister will be aware that we have heard from the Food and Drink Federation Scotland, which has real concerns about manufacturers having to adhere to two regimes—the Great Britain regime and the Northern Ireland-EU regime. Is not that likely to be detrimental to trade within the UK and from the UK to the EU?

Mairi Gougeon: I absolutely agree. The impact on Scottish businesses that supply Northern Ireland is of huge concern. David Stewart is absolutely right; as a result of the Northern Ireland protocol, businesses that export to Northern Ireland will have to ensure that they are compliant not only with regulations and law in the relevant part of the UK, but with EU law.

Over the course of the past couple of days, we have seen smaller businesses in Scotland ruling out exporting their produce to Northern Ireland, purely because of that bureaucratic burden and the extra work that it has put on them, which is simply not sustainable.

There is, of course, a further irony in that there is no mutual recognition. Any business that wants to trade with the EU has to meet EU standards. Although the UK might be able to diverge for some markets, for the EU market—which is by far our largest—EU requirements must still be met. Irrespective of any legal alignment under the deal, the friction that is currently being built is symptomatic of the UK's status as a third country outside the EU, and of Northern Ireland's status as set out in the Northern Ireland protocol.

George Adam: Good morning, minister, and welcome to your new post. I hope that you do extremely well.

You said of the UK Internal Market Act 2020 that it is the biggest threat to the frameworks and that it creates complexity that did not previously exist. Can you give us more detail on how the act will impact on and interfere with how the frameworks operate?

Mairi Gougeon: As I have said in my responses to previous questions, the positive part of the frameworks is that they build on existing relationships and work on the basis of the four nations coming together equally to manage divergence in respect of devolved competences. They respect the fact that we might do different things and they try to manage that as well as possible. The four nations had managed to reach agreement on that approach.

The UK Internal Market Act 2020 is a massive threat to agreement on and implementation of the common frameworks, because the incentive to manage policy divergence is completely removed if standards that are set in one part of the UK must automatically be recognised in all other parts. As Emma Harper suggested earlier, the relative size of the production bases means that food law will be determined across the UK as a whole, and in no small part by the Administration that has the biggest sectoral interest. That is of huge concern to us.

Late amendments to the bill allow disapplication of the market access principles from individual legislative measures in common framework areas. However, that decision can be applied unilaterally by the UK Government. The fallback is that it would always be the UK secretary of state who would have the final decision. Again, as I have said, that removes the incentive for co-operation that we had established through the common frameworks process. It also undermines a key plank of the framework, which is that ministers would be able to take decisions for their own countries. At its worst, the act makes that whole process irrelevant.

We consider that the common frameworks are all that are needed to ensure that internal market issues are considered in policy development. The vast majority of stakeholders feel the same. Our analysis of the Internal Market Act 2020 is that irrespective of the necessity for or proportionality of any public health priority in Scotland—or any other part of the UK—any national measure could be caught and undermined by automatic application of the act's market access principles. That is of huge concern and undermines the process with which we have been engaging in good faith.

Geoff Ogle: I will make two quick points on that. First, divergence, or the ability to diverge, is not a new concept: it was a concept when we were members of the EU. Secondly, there is, even when we were within the EU, a history of divergence within the UK on a range of policy areas, with policy being tried and tested in one area then rolled out across the UK. To take a non-Scottish example, plastic bag charges were introduced first in Wales, then that policy was rolled out. There is concern that divergence is being seen as a bad thing that could interfere with the internal market. However, in public health terms, and in a range of other areas, divergence is a good thing because it enables improvements that could then have wider application.

Finally, the principle behind the frameworks is that they should be common frameworks; divergence is not an objective, in itself. Through the frameworks there is recognition that where divergence can be objectively justified and there is a rationale for it—in this context, a public health rationale—it can be enabled.

George Adam: On the minister's final point, we have been told by people who think that they are very important that the new office for the internal market is very important. How are Scottish interests being represented in that new office? Who will represent Scottish interests?

Mairi Gougeon: I would describe the office in much the same way as I have described the act; I would say that it is completely unnecessary. Structures already exist for gauging the market impact of proposed new measures and sharing such information among Administrations and relevant agencies. We therefore see the office as being not really essential. Perhaps our view would be different if the UK Government had been willing to consider sharing the chairing of it or moving it around. However, the UK Government has very much held to itself the rights to monitor and to provide advice. I have concerns about how Scottish interests will be represented in the office. The committee should put to UK Government ministers questions on how they will recognise Scotland's interests within that system.

Euan Page (Scottish Government): I will add to the minister's points by highlighting that the act was amended to bring in additional provision on the composition of the office for the internal market, including a requirement to seek consent for specifically Scottish appointments to the body. However, if such consent is not forthcoming, UK Government ministers can proceed after a delay of one month. In the rules on the body's composition there is very little to provide for certainty that Scottish ministers' views will be reflected on the board. It is important not to overemphasise the suggestion that the office for the internal market provides any safeguard or means of working against direct application of the act's market access principles.

David Torrance: Good morning, everyone. I welcome the minister to her new position.

The committee heard, from the Food and Drink Federation Scotland, concerns that manufacturers will have to adhere to two regulatory regimes, which is likely to be detrimental to trade both within the UK and from the UK to the EU. Is there any early evidence of such an impact?

Mairi Gougeon: As I said in earlier answers, we have already seen businesses giving up on exporting because of the bureaucratic burden that now exists. I absolutely agree about the concerns that have been highlighted by the Food and Drink Federation Scotland on the impact that the situation will have, and is already having, on Scottish businesses that supply Northern Ireland. Those concerns will also apply to trade between Scotland and the EU that is routed through Northern Ireland.

As I said earlier, because of the Northern Ireland protocol businesses will have to ensure that they comply with two sets of legislation, which will automatically be a huge new burden for them. A number of small businesses have already stopped trading. I hope that we will not see more of that and our relationships with Northern Ireland decreasing through there being fewer people looking to trade there. That is the reality of where we currently are because of the need to adhere to two regimes.

Brian Whittle: I welcome the minister to her position.

I am interested in exploring the dispute resolution mechanism. In his written evidence to the committee, Professor Paul Haggarty said:

> "The Framework repeatedly stresses that disagreements will be rare and there is a lot of emphasis on goodwill and the desire for the nations to work together constructively."

He also suggested that it is

> "more likely that differences between nations will arise primarily in relation to risk management and the interpretation of evidence."

Does the minister agree with Professor Haggarty that it would have been useful to stress test the likely effectiveness of the framework by exploring difficult scenarios that are actually quite likely to arise?

12:00

Mairi Gougeon: In an ideal world, we would not be having to go through the process of live testing the framework right now; ideally, we would have gone through scrutiny and had everything in place by the end of the transition period. The current situation could have been avoided. However, we are where we are. Ideally, we would have done everything and been prepared beforehand.

On some of the other points, including the one that was made by Geoff Ogle, our starting point is not automatic divergence. We are building frameworks based on close working relationships that already existed; for example, I have talked about the memorandum of understanding between the FSA and FSS. There are many on-going relationships and communication right across the UK, among all the interested organisations. That gives me hope when it comes to the dispute resolution mechanism that is laid out in the framework. We will not automatically dispute

everything; as I said, our starting point is not policy divergence.

However, the dispute resolution process is there, should issues emerge, and it will, I hope, mean that issues are resolved as early as possible. That process would be triggered only as a last resort; every effort would be made to reach consensus on matters that are within the scope of the framework, which should to some degree mitigate the risk of escalation.

Brian Whittle: The committee considers itself to be a conduit between stakeholders and the Scottish Government. How will you keep the committee informed, and the Parliament up to date, on implementation of and changes to the common framework, including proposals for related legislation, as the process goes along?

Mairi Gougeon: Essentially, I want to assure the committee that I and the Scottish Government absolutely believe that there has to be effective parliamentary scrutiny of that, so I would seek to keep Parliament and the committee updated and to keep the flow of information going as much as possible. I believe that discussion about how we will do that is on-going between Scottish Government officials and Scottish Parliament officials.

Again, one of the key ways in which Parliament would engage with the framework would be through being asked to make decisions on the Government seeking to change legislation. That will go through the normal scrutiny process. I reiterate that the frameworks that we are developing are, in essence, mechanisms for work between Administrations. Their critical function is to deliver recommendations for statutory change that we might want to implement, and such proposed changes will drive Parliamentary engagement with the framework.

Of course, I will continue to keep the Parliament updated, because, as I said at the start of my response, I think that we need that effective scrutiny.

The Convener: I thank the minister and her officials for taking part in our meeting today. It has been extremely helpful to committee members. We will consider our further response to the provisional framework in due course; indeed, we will do so later this morning.

Subordinate Legislation

Health Protection (Coronavirus) (International Travel and Public Health Information) (Scotland) (No 2) Regulations 2020 (SSI 2020/444)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 25) Regulations 2020 (SSI 2020/474)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment Regulations 2021 (SSI 2021/5)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/6)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 3) Regulations 2021 (SSI 2021/7)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 4) Regulations 2021 (SSI 2021/19)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/21)

Health Protection (Coronavirus) (Pre-Departure Testing and Operator Liability) (Scotland) Regulations 2021 (SSI 2021/20)

12:04

The Convener: We move to items 3 and 4 on the agenda, which are consideration of made affirmative instruments that, once again, relate to international travel in the context of the coronavirus. On this occasion, we have a total of eight sets of regulations in front of us, which the Cabinet Secretary for Transport, Infrastructure and Connectivity will describe in due course.

We will have a single evidence session on the instruments with the cabinet secretary and his officials, and then we will have two formal debates on the motions. The first will be a joint debate on the instruments relating to the removal and addition of specified countries and territories and,

ultimately, the removal of all overseas countries and territories from the exemption list; the second will be a debate on the new scheme for pre-departure testing of passengers travelling to Scotland.

I welcome Michael Matheson, Cabinet Secretary for Transport, Infrastructure and Connectivity. On this occasion, he is accompanied by three officials from the Scottish Government. Craig Thomson is the border measures review team leader, David Pratt is policy lead for the health performance and delivery team, and Peter Brown is from the police enforcement, liaison and performance team.

Thank you for joining us again today, cabinet secretary. As you will have heard, we intend to deal with these agenda items in a way that allows us to ask questions on all the Scottish statutory instruments at the outset before having two separate debates covering the separate areas.

You may wish to make a short statement to introduce the regulations and describe their content.

The Cabinet Secretary for Transport, Infrastructure and Connectivity (Michael Matheson): The regulations that the committee is considering today make a significant number of changes over a short period of time.

The Health Protection (Coronavirus) (International Travel and Public Health Information) (Scotland) (No 2) Regulations 2020 (SSI 2020/444) was the last of the regular weekly country exemption changes of 2020. The four nations agreed to pause that process over the festive break, with an emergency escalation route put in place. That was put into effect shortly before Christmas, with the identification of a concerning variant in South Africa. The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 25) Regulations 2020 (SSI 2020/474) therefore placed additional restrictions on travel from South Africa. Those were the same as the measures that were used in response to the Denmark variant, and they included the removal of sectoral exemptions and a requirement on households to isolate. We then extended those additional restrictions to a range of countries in the southern Africa region, through the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment Regulations 2021 (SSI 2021/5), following further advice from the joint biosecurity centre.

Early in January, we were faced with a significant number of cases coming back from Dubai, which we picked up in the test and protect data for Scotland. In addition to conducting our own investigations, we alerted the JBC on the Friday afternoon, and it began to examine the issue within the wider UK context. By the Sunday, it was clear that we needed to act in Scotland's interests in order to deal with the increasing numbers. On the advice of the chief medical officer, we took targeted action to remove Dubai from the exemption list. That is dealt with in the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/6).

The JBC then convened a full risk assessment of the United Arab Emirates on the Monday morning and recommended that the UAE should be removed from travel corridors immediately. We aligned with the other nations by extending our existing targeted measures to take all of the UAE out of the exemption list. That was dealt with in the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 3) Regulations 2021 (SSI 2021/7).

The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 4) Regulations 2021 (SSI 2021/19) relate to risks from new variants. A new concerning variant was identified in Brazil and Argentina. All four UK nations placed additional restrictions on travel from South America and Portugal, based on a risk assessment by the JBC.

The speed of those changes and the rate at which new variants are emerging meant that we had to re-examine the existing processes. The JBC has told us that the data is not available to allow it to adequately locate and assess risk from new variants. The country exemption process is, therefore, not fit for purpose, which led to the decision, through the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/21), to remove all countries and territories from the exemption list.

Finally, the Health Protection (Coronavirus) (Pre-Departure Testing and Operator Liability) (Scotland) Regulations 2021 (SSI 2021/20) deal with the introduction of pre-departure testing, which requires anyone travelling to Scotland to have a negative test result a maximum of 72 hours before starting their journey back to Scotland. Test results will be checked by those operating flights or any other form of transportation into Scotland, as well as by Border Force at the point of entry to the country. Those measures are provided for by SSI 2021/20, which is now in effect in Scotland.

The Convener: We will proceed to questions. Committee members should indicate that they want to ask a question by typing R in the chat box. I will start.

Given the changes that have been made and the ending of the country exemption arrangements, what will happen in situations where citizens are stranded abroad? What support

will they be given and what actions will be taken to enable them to return?

Michael Matheson: The requirement is that the operator of a flight, for example, is required to ensure that individuals have the appropriate certification of a negative test before they are allowed to board the flight. Should an individual not have that certification, they will not be allowed to board the flight, and the legal responsibility rests with the operator to ensure that that happens. Should someone have difficulty—there are some countries where it may be difficult to access the appropriate level of pre-departure testing—there are some very limited exemptions in the regulations to take account of that. Anyone who is travelling internationally should be doing so only if it is absolutely essential, and it is important that anyone who is travelling makes arrangements to ensure that they have access to a test prior to returning. It is incumbent on individual travellers to ensure that they have adequate arrangements in place to have the test conducted and completed prior to starting their journey back to Scotland.

The Convener: The approach to enforcement of many of the regulations relating to quarantine arrangements or requirements placed on travellers that the committee considered in 2020 was perhaps best described as “light touch”. Given the tougher approach to travelling in and out of the country now, what is the Scottish Government planning for the enforcement of quarantine when travellers return to the country in the next few weeks?

Michael Matheson: You raise an important point. We have already started to take action on that issue. One example is the approach that is being taken by the national contact tracing centre. Anyone returning from a high-risk country, such as South Africa or countries in South America, is prioritised for contact by email and phone on their return to Scotland. We are also looking at scaling up the number of individuals who are directly contacted once they return to Scotland. You will be aware that the national contact tracing centre has been contacting around 2,000 individuals each week on their return to Scotland. We are looking at directly contacting by phone all individuals returning to Scotland from international travel. The national contact tracing centre has already started the process of ramping up its services. Last week, it reached more than half of those who returned to the country, which reflects the increasing priority that we are placing on the need for the centre to contact those returning from international travel. We are assessing what additional capacity will be needed to ensure that everyone is contacted directly on their return.

12:15

We are looking at what measures we can put in place to enhance compliance with self-isolation, such as the work that we are taking forward on the introduction of what are often referred to as quarantine hotels. We have been discussing that measure with the UK Government and we are assessing the most appropriate and effective model to implement in Scotland.

In addition, we are considering whether we could use some form of technology to assist us in improving compliance with any period of self-isolation that an individual has to complete at home. For example, we are looking at the existing test and protect app to see whether it can be amended to help us to engage with individuals during their period of self-isolation following international travel.

A range of work is therefore being taken forward to look at improving compliance as well as introducing further constrictions to ensure that people comply with any period of self-isolation.

Emma Harper: Good morning, cabinet secretary. I have a couple of quick questions. Does it matter whether a pre-boarding negative test is a polymerase chain reaction test or a lateral flow test? Do we know why people do not comply with self-isolation? How would we address that if we use quarantine hotels?

Michael Matheson: The specificity and sensitivity of the pre-departure test that someone is required to have completed are set out in the regulations. It is close to being a PCR test, so many of the lateral flow tests will be insufficient because they are not sensitive enough, although some of the better-quality lateral flow tests might be compliant. The higher threshold for the specificity and sensitivity of the pre-departure test is set out in the regulations and is close to being the level that is specified in a PCR test.

You asked about quarantine hotels and why people do not comply with self-isolation at present. The basis of non-compliance for many people will probably be because they think that they do not have any symptoms and do not pose any risk, and therefore they choose not to comply with the regulations as they stand. There could be a range of other reasons behind that as well that might be work related or family related, for example, which result in people feeling that they do not wish to, or cannot, comply with the regulations.

However, we have to recognise from the COVID-19 Genomics UK Consortium report that was published at the beginning of December that the introduction of new types of the virus into the country through international travel is a key issue that we need to address effectively if we are to continue to suppress the virus across the whole

country. That is why we are looking at measures to enhance compliance through, for example, the app approach and through the introduction of quarantine hotels.

We know that when such measures have been deployed in other parts of the world, they have proven to be effective in ensuring greater compliance and reducing the risk of the importation of the virus. That is why we have been engaging with the UK Government on the matter. I would like to get four-nations agreement on it and align it on a four-nations basis. If we work on the basis of what we are hearing from the UK Government at present, I do not think that that will go far enough. We therefore might have to take further measures in Scotland in order to be satisfied that we have the safeguards that are necessary when it comes to the use of quarantine hotels.

Sandra White: Thank you for that, cabinet secretary. I very much support the SSIs that are before us. I know that the Scottish Parliament does not have the powers to address the issue of international travellers entering the country, but this measure should have been taken a long time ago, particularly given that new variants of the virus are now in Scotland.

I want to know a wee bit more about the timescales for compliance with isolation. Also, do we have a timescale for the introduction of quarantine hotels? In addition, at the end of your comments to Emma Harper, you mentioned that we might have to take additional measures in Scotland if the four nations cannot agree. Can you give us an idea of what those measures could be? I really believe that if we had locked down international travel earlier, we would not be in the position in which we are now.

Michael Matheson: On the overall compliance with quarantine, I believe that the committee has already considered that issue. It is difficult to provide reliable data on the level of compliance with quarantine where it involves self-isolation at home, because it is difficult to check on each individual. Therefore, we want to look at means by which we can increase compliance with any period of quarantine, hence our consideration of quarantine hotels—and technology—as a means to support that.

On the question about quarantine hotels, as things stand, if we were to decide today that we were going to introduce quarantine hotels, it would probably take about two to three weeks before that became operational. That wold depend on the number of people coming into the country that would have to make use of them.

There is also a particular challenge in that we have a low number of international flights coming into Scotland, at present. Figures from last week show that about 1,000 to 1,500 individuals travelling internationally—largely from Doha and Dubai—to Scotland on direct flights. However, there are an even greater number of individuals from Scotland travelling internationally who are coming in through hubs such as Heathrow. If those people were required to self-isolate as a result of a restriction that we put in place in Scotland, that self-isolation would have to take place at their point of entry into the UK, because it would potentially be unsafe for them to travel from London to Scotland to carry out their period of self-isolation. We would therefore have to engage with the UK Government on a number of operational issues before we could implement that.

However, at this stage, it is unclear exactly how far the UK Government intends to go. I can operate only on the basis of what is in the press and the speculation around that, because the UK Government has not shared the detail of its assessment with us. That is despite our agreeing with the UK Government more than a week ago that we wanted to consider the introduction of quarantine hotels on a four-nations basis. That is disappointing, and it has hampered our ability to ensure that we can adequately engage in the decision-making process on what any final quarantine hotel arrangement might be across the four nations. If the UK Government does not go as far as we believe is necessary, it might be that we will have to take additional steps in Scotland around use of quarantine hotels.

Another aspect that we are considering is reviewing all the existing sectoral exemptions in order to consider whether they remain justified and whether some of them should be closed down—[*Inaudible*.].

The only other aspect that we are considering is, as I have mentioned, how we can increase compliance with required periods of self-isolation and how those could be reinforced at points of entry into the country.

Sandra White: Thank you for that detailed reply, cabinet secretary.

The Convener: As members have no further questions, we will move to agenda items 5 to 11, which are the formal debates on seven of the made affirmative instruments on which we have just taken evidence. Those are SSI 2020/444, SSI 2020/474, SSI 2021/5, SSI 2021/6, SSI 2021/7, SSI 2021/19 and SSI 2021/21.

Are members content that we hold a single debate to cover all those instruments?

As no members object, we will hold a single debate.

During the formal debate questions may no longer be asked and officials may not speak, but members will have an opportunity to contribute. I invite the cabinet secretary to move the motions en bloc.

Motions moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel and Public Health Information) (Scotland) (No 2) Regulations 2020 (SSI 2020/444) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 25) Regulations 2020 (SSI 2020/474) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment Regulations 2021 (SSI 2021/5) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/6) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 3) Regulations 2021 (SSI 2021/7) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 4) Regulations 2021 (SSI 2021/19) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/21) be approved.—[*Michael Matheson*]

The Convener: Do any members wish to contribute to the debate?

Sandra White: I will not reiterate my previous points, but I am very concerned, as are many other people, that 1,000 to 1,500 individuals are coming directly to Scotland on international flights. We hope that the plans will go ahead, but I have real concerns about the flights that come into hubs, particularly Heathrow and other airports in that area. I ask the cabinet secretary and his officials to press the Westminster Government, as I know they will, not to allow people on those flights to travel to Scotland without there being a four-nations approach to isolation, and perhaps on hotels, too.

We have to get a grip on the situation. We are now seeing the new variants from South Africa and Brazil—with some cases coming via Dubai in the United Arab Emirates—in the Scottish islands. The measures should have been taken a long time ago to prevent spread of the Covid-19 virus. I reiterate that we must pressure Westminster into saying that people who come in via Heathrow must isolate at the point of entry. We cannot have the virus spreading any further. People are dying, and people are suffering terribly from having to stay in their houses. I make that plea as my contribution to the debate.

Emma Harper: I was not planning to contribute, but I have another concern on the back of what Sandra White said about people flying into airports such as Heathrow. I am concerned about people flying into Dublin, for example, which is in the EU, and taking a short drive to the ferry port at Larne or Belfast and then taking a short ferry journey to Scotland. What work is being done, and how are we working together not only on the four-nations approach, but with our neighbours in Ireland to make sure that we continue to protect people, especially as we are seeing the new variants arriving in our islands?

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

Michael Matheson: I am grateful to Sandra White and Emma Harper for their comments. On Sandra White's concerns around the issue of hubs such as Heathrow and the risks associated with the new variants, my principle concern at present is that, from what I see in the press, the UK Government is considering targeting the use of quarantine hotels at individuals returning from what are viewed as high-risk areas where new variants have been identified—namely, South America and southern parts of Africa.

12:30

The challenge with that approach is that the joint biosecurity centre has made it clear that it is not able to assess and advise on where those high-risk areas are until the new variants have been identified. Therefore, in my view, the proposed system would offer only very limited additional protection. That is why we believe that the use of quarantine hotels needs to be extended to a larger group of people who are returning to the country, rather than covering just those who are returning from areas that are viewed as high risk. As yet, it is unclear to us what methodology or approach the UK Government intends to use with regard to quarantine hotels, if it chooses to take that route. We will have to wait and see what information it provides us with based on its own assessment.

With regard to Emma Harper's point about the Republic of Ireland, I assure her that the discussions between the four nations are also looking at matters relating to the common travel area, which includes the Republic of Ireland. The issue has been raised on a number of occasions by my counterpart in the Northern Irish Government with regard to the transfer of information between the Republic of Ireland and Northern Ireland on any passengers who may be

travelling through Dublin. The matter is being pursued, to try to address the concerns that Emma Harper raised.

The Convener: I ask members to confirm that they are content that a single vote be held on the seven motions.

I see that members are content to do that. The question is, that motions S5M-23757, S5M-23812, S5M-23887, S5M-23886, S5M-23851, S5M-23922 and S5M-23897, be agreed to.

Motions agreed to,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel and Public Health Information) (Scotland) (No 2) Regulations 2020 (SSI 2020/444) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 25) Regulations 2020 (SSI 2020/474) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment Regulations 2021 (SSI 2021/5) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/6) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 3) Regulations 2021 (SSI 2021/7) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 4) Regulations 2021 (SSI 2021/19) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/21) be approved.

The Convener: We move to item 12, which is the formal debate on the Health Protection (Coronavirus) (Pre-Departure Testing and Operator Liability) (Scotland) Regulations 2021 (SSI 2021/20), on which we have taken evidence.

Motion moved,

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (Pre-Departure Testing and Operator Liability) (Scotland) Regulations 2021 (SSI 2021/20) be approved.—[*Michael Matheson.*]

Motion agreed to.

The Convener: We will issue a report to Parliament accordingly. I thank the cabinet secretary and his officials for their attendance at this evidence session.

Petitions

NHS Centre for Integrative Care (PE1568)

Whistleblowing in the NHS (PE1605)

Community Hospital and Council Care Home Services (PE1710)

12:33

The Convener: Item 13 is consideration of three outstanding petitions that remain on the committee's desk. Members will have seen the clerk's note regarding the Public Petitions Committee's request for any outstanding petitions to be considered and disposed of by the end of the month. PE1568 is on funding for, access to and promotion of the NHS centre for integrative care; PE1605 is on whistleblowing in the national health service and a safer way to report mismanagement and bullying; and PE1710 is on community hospital and council care home services in Scotland.

Colleagues may want to address the petitions individually We should acknowledge that we are approaching the end of the current parliamentary session, so it might therefore be appropriate for us to discontinue consideration of petitions from this session. Some of the petitions raise issues that may be brought back to Parliament in the next session in a more up-to-date petition.

Emma Harper: I note that the Public Petitions Committee, in my understanding, is reviewing the process for presentation of petitions to committees, so the process in the new parliamentary session might be different from the process for the current one. I raise that point to ensure that members are aware of it. It means that, at this point, we might be able to close some of the petitions, but if there are questions that still need to be answered in relation to them, the process for doing that might change.

The Convener: That is an important point, which is reflected in what we have seen from the Public Petitions Committee and its suggestion that we dispose of the petitions now in order that its successor committee will have a clean sheet and be able to address issues with new petitions in the new parliamentary session.

Brian Whittle: As someone who was on the Public Petitions Committee for a number of years, I have a concern. It has always been the case that petitions are carried forward into the next session. As Emma Harper says, the PPC is looking at whether that will remain the case.

I have received a note regarding Catherine Hughes's petition; the cross-party group on chronic pain unanimously agreed that it does not want that petition to be closed. What would be the implications of not closing that petition? Would we have an opportunity in this parliamentary session to make any further progress on it? That is the crux of the matter.

The Convener: It is, and the short answer to your last question is that it is very unlikely that this committee will have further consideration any outstanding petitions during this parliamentary session. As members know, we are rapidly approaching the end of the session and the committee must still deal with a number of items of business.

The implication is that it is open to this committee now to close the petitions, and it will be open to the petitioners, with or without support from members of Parliament, to submit new petitions in the new parliamentary session that cover any aspects of a previous petition that have not yet been addressed. That will offer the future Public Petitions Committee a tidier way to deal with matters, and will allow petitioners to submit something that is more up to date and relevant than a petition might be after it has been lying on the table for some time.

David Torrance: I fully support what you saying, convener. As a member of the Public Petitions Committee, I can say that time is very short for that committee. That approach would allow petitioners to bring back petitions, probably in updated versions, in the new parliamentary session to allow the PPC to look at them again.

The Convener: That is clear and appreciated. We move to formal consideration of the proposal to close each petition.

Do we agree to close petition PE1568?

Members *indicated agreement.*

The Convener: Do we agree to close petition PE0165?

Members *indicated agreement.*

The Convener: Do we agreed to close petition PE1710?

Members *indicated agreement.*

The Convener: We will therefore report back to the Public Petitions Committee that we will not consider those petitions further, and that we look forward to hearing, in due course, what new arrangements will be put in place.

12:39

Meeting continued in private until 12:56.

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