OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 24 February 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 24 February 2022

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COVID-19 RECOVERY COMMITTEE

6th Meeting 2022, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Andrew Elder (Royal College of Physicians of Edinburgh)
Professor Jason Leitch (Scottish Government)
Dr Barbara Miles (Scottish Intensive Care Society)
Dominic Munro (Scottish Government)
Dr David Shackles (Royal College of General Practitioners Scotland)
John Swinney (Deputy First Minister and Cabinet Secretary for Covid Recovery)
Dr John Thomson (Royal College of Emergency Medicine)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 24 February 2022

[The Convener opened the meeting at 09:00]

Excess Deaths Inquiry

The Convener (Siobhian Brown): Good morning, and welcome to the sixth meeting in 2022 of the COVID-19 Recovery Committee. This morning, we will take evidence on excess deaths in Scotland since the start of the pandemic.

I welcome to the meeting Professor Andrew Elder, president of the Royal College of Physicians of Edinburgh; Dr John Thomson, vice-president of the Royal College of Emergency Medicine in Scotland; Dr David Shackles, joint chair of the Royal College of General Practitioners Scotland; and Dr Barbara Miles, president of the Scottish Intensive Care Society. I thank the witnesses for giving us their time and for providing written evidence to the committee.

This session will be the first of two evidence sessions with stakeholders as part of the excess deaths inquiry. Then, on 17 March, we will hear from the Cabinet Secretary for Health and Social Care and from Public Health Scotland.

Each member will have approximately 12 minutes to speak to the witnesses and ask their questions. We should be okay for time this morning, but I apologise in advance if time runs on too much and I have to interrupt members or witnesses in the interests of brevity.

I ask our witnesses to say a few words to introduce themselves.

Dr John Thomson (Royal College of Emergency Medicine): Good morning. I am a consultant in emergency medicine in Aberdeen and the chair and vice-president of the Royal College of Emergency Medicine in Scotland.

Professor Andrew Elder (Royal College of Physicians of Edinburgh): Good morning. Thank you for the opportunity to participate in the meeting. I am representing the Royal College of Physicians of Edinburgh, which includes people with a wide range of specialties. I am a consultant geriatrician in practice.

Dr David Shackles (Royal College of General Practitioners Scotland): Good morning. I am a general practitioner in Perth and one of the joint chairs of the Royal College of General Practitioners Scotland, which is a membership organisation that promotes quality and excellence in general practice throughout Scotland. We are allied and work closely with our colleagues in England at the Royal College of General Practitioners.

Dr Barbara Miles (Scottish Intensive Care Society): Good morning. I am a consultant in intensive care medicine and anaesthesia in Glasgow. I am here as the president of the Scottish Intensive Care Society, which represents professionals working in intensive care units throughout Scotland.

The Convener: I thank all the witnesses for their written submissions, and everybody else who responded to the committee's call for evidence.

The first thing that stood out to me when the committee launched its inquiry was that Scottish Government data showed that the number of deaths in Scotland was 11 per cent above the average for that time of year, and that it had been, on average, for the previous 26 weeks. That caused us alarm, and we wondered whether that would be a growing trend. However, the data that was published on 14 February shows that the number of deaths in Scotland is currently 6 per cent below average. Does anyone have any insight on, or explanation for, that trend?

Professor Elder: Your question highlights one of the main issues, which relates to the time period in which we will be able to make conclusive judgments about the impact of the pandemic on total mortality and on what we are allocating as non-Covid mortality, which is much more difficult to assess.

As you highlighted, there will be short-term fluctuations. That is, in part, due to a phenomenon that some people describe as mortality displacement. In a given time period, some individuals—particularly the frail and vulnerable—might die a little earlier because of, in this case, the arrival of a new condition. That could explain, in part, the current decline in mortality that you have highlighted.

Given the fact that, over short periods of time, we will see the kinds of fluctuations that you have highlighted and given the additional fact that some of the potential impact of the pandemic and the way in which we have had to manage it will be apparent only over a longer period of time—I and many of my colleagues believe that there will be a lag effect—we should be very careful not to draw quick conclusions from the data. We will have to wait a considerable period of time—years, probably—to gauge the pandemic's full impact on mortality and, indeed, morbidity.

Dr Miles: I agree with Professor Elder. The effects of the pandemic on the population and the health service will be long term rather than short term, and it will take some time to see them fully.

The Convener: My second question relates to a point that one of my colleagues brought up in the private briefing that we had before the meeting. The majority of respondents who answered our call for evidence did not think that there had been enough of a strategic focus on non-Covid conditions and suggested increasing staff and bed numbers. We will all appreciate and understand the pressure that there has been on the national health service over the past two years and that you cannot just magic up staff and beds overnight. However, can anything be done in the short term to address the backlog, given that so many capacity challenges still exist? Moreover, could the Government do anything in the short term to bolster the health and social care workforce?

Professor Elder: I think that you are correct to say that the key to recovery is capacity with regard to both the workforce and facilities and that we cannot magic up either more beds or a bigger workforce.

We are already doing this to some extent with the proposal for national treatment centres, but we could attempt to separate elective and emergency care in a better way. A factor that contributes to the waiting list issue in elective surgery—this applies not just to the pandemic but to our usual Scottish winters—is the unwanted impact on elective care of increased demands for emergency care. As members will know, it has been suggested that separating elective care and urgent care might help with the situation.

Secondly—I highlight this particularly as a geriatrician—recovery is a whole-system issue. I am interested primarily in the efficiency of our hospitals, but they can operate at maximum efficiency for either elective or urgent care only if we can get people out of hospital quickly. In Scotland, we have a substantial problem with what is often called exit block or delayed discharge—with enabling people who do not wish to be in hospital to get home more quickly. That is not new; we have had it for a while. In my opinion, though, the solution to that is not simple, because it primarily comes down to the workforce that is available for social care and particularly for the delivery of domiciliary care in patients' homes.

Those two issues could be—or, I should say, have been—considered in helping to mitigate the problems.

Dr Thomson: I want to expand slightly on the point that Professor Elder made. I agree with everything that he has said. We know that there is a clear relationship between particularly long waits for beds—that is, patients waiting more than 12 hours in emergency departments for a bed—and subsequent cancellations of elective activity. It is very pertinent that any future strategy for elective care should involve unscheduled care, because they cannot be looked at in isolation.

As Professor Elder said, one of the greatest challenges in separating elective and emergency care is the workforce. We have a single workforce in Scotland, and we do not currently have the workforce that would be required in order to separate elective and emergency care, despite the desire to do so.

Dr Shackles: I whole-heartedly agree with Professor Elder's comments about the capacity of the workforce in community care, particularly in the care home sector, which has been a particular problem throughout the pandemic. Any community care is absolutely necessary. Even pre-pandemic, we had significant workforce issues throughout general practice and primary care. The pandemic has shone a spotlight on that. We need to be absolutely certain and look at a good workforce strategy, along with the Government, to try and rectify that. I see that that has been highlighted in this morning's Audit Scotland report, which makes exactly that point—that we need to look at care in the community rather than rely on sending more people into hospitals, which we do not have the capacity for.

On looking for solutions for that in the short term, it takes 10 years to train a general practitioner. That will be a struggle at present. We have to look at adequate retention of the workforce in all sectors. We cannot afford to lose anybody from the workforce. We have to try to keep people working at a reasonable level, using the skills that they can deliver. Retention is absolutely critical.

The other good way of winning is to work smarter rather than more or harder. We believe that we can make things better by improving the interfaces of care—particularly the interfaces between primary and secondary care—in order to get better, smoother, more effective and more efficient pathways for patients. That can smooth a patient's journey, make it more effective, use less resources, and get people treated in a more timely manner.

The Convener: Thank you very much. That is very interesting.

Dr Miles: I will echo what my colleagues have said. There is a finite workforce in the NHS and health and social care in Scotland. Much as new centres may be desired, it is very difficult to open centres without denuding staff from the existing workforce in other places. I agree with Dr Shackles that we need to retain the staff whom we already have. The pressures of the pandemic have resulted in a large volume of experienced staff seeking work elsewhere or seeking early retirement. We lose a lot of experience and skills

in the workforce when that occurs. In the short term, measures to retain those staff in the workforce would help with some of the challenges that we will face.

The Convener: Brilliant. Thank you very much for your answers. We will move to questions from Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. My first question is for Dr Thomson, in relation to the written submission that you have made on behalf of the Royal College of Emergency Medicine.

I was very struck by the comments that you made about the impact of delays in patients being admitted to emergency departments. You highlighted ambulance stacking. We know that there are delays with ambulances being able to attend and ambulances queueing up outside emergency departments. You go on to say that your estimate is that, in 2021, delays in admissions equated to more than 500 excess deaths in Scotland. That is an extraordinary and extremely worrying statistic. That means that 10 people a week are dying because they cannot get treatment in time. Can you tell us more about how you arrived at that figure and what its impact is?

09:15

Dr Thomson: Thank you for that question. Evidence was published in the *Emergency Medicine Journal* last month, subsequent to Getting it Right First Time's emergency medicine in England report, which was published in September, that showed a clear correlation between long waits for beds—in essence, patients waiting in emergency departments to be moved to the appropriate clinical area—and mortality.

For patients waiting longer than six hours in an emergency department, what is known as the number needed to harm is 1 in 77. That means that, for every 77 patients who wait longer than six hours, one will die within 30 days as a result of that wait. For patients who wait longer than eight hours, the number needed to harm is 1 in 67. There is a clear association between long waits in the emergency department and mortality. The studies were unable to clarify the harm because of long waits that did not result in death, but that is clearly a much greater problem.

In 2021, almost 13,000 patients waited longer than 12 hours in our emergency departments, which is a greater number than in the previous three years combined, yet 2021 saw our second-lowest ever annual attendance at emergency departments nationally. That comes down to a point that Professor Elder mentioned earlier about exit block. There is exit block of patients leaving hospital, which impacts on capacity, and there is exit block of patients leaving crowded emergency departments. The waits of those patients impact on ambulances ability to unload. Unfortunately, there is no safe clinical space in our emergency departments to receive undifferentiated unwell patients, because of the issues that we have with patient flow in our hospitals.

Murdo Fraser: Thank you, Dr Thomson, that was a helpful response. There are a couple of things in what you said that I want to follow up on.

Clearly, we have had a big problem over the past two years with intensive care unit beds being taken up by Covid patients. It seems that that is now on a downward trend, which is very positive. What have you picked up over the past few weeks about future trends? Do you expect the issue with delayed admission to start to work itself through, or is it with us for the longer term?

I have a second question, which I will ask now, to save time. There is clearly a workforce issue—that was mentioned in an earlier discussion in response to a question from the convener. You make the point in your submission that, even before Covid, emergency departments were "understaffed and under-resourced". How do we solve that in the short term? Recruitment takes time; Dr Shackle said that it takes 10 years to train a general practitioner. I imagine that it takes a similar length of time to train staff in emergency medicine. Even if we started ramping up recruitment now, it would take a long time to work through the system. We probably cannot recruit from other countries, because they face exactly the same challenges that we are facing—quite apart from there being ethical issues in bringing to Scotland medical staff who have been trained in poorer countries. What more can be done to address the staffing issue and help us, without our having to wait 10 years for more medical staff to be trained here?

Dr Thomson: In answer to your first question, the issue with prolonged patient waits in emergency departments is not a Covid phenomenon. It has existed for many years and, in the first wave, when there was a stepping down from all other scheduled activity, patients did not wait at all to move from emergency departments, because there was available capacity in hospitals. It is a chronic problem—the majority of patients whom we see in our emergency departments are non-Covid patients. The college estimates that we are approximately 1,000 acute beds short across the country, which obviously exacerbates the problem.

There being long waits in emergency departments is not a new problem. However, ambulances waiting to offload is a relatively new problem. The reason for it is that, during Covid, significant infection prevention and control

measures were put in—not just in emergency departments, but throughout hospitals. That has meant that patients being offloaded to a corridor, as would have happened previously, has—thankfully—been deemed to be no longer acceptable. Before Covid, the patients whom we now see waiting in ambulances outside emergency departments to be offloaded were lying in corridors inside the departments, which was neither desirable nor an acceptable level of care. Covid simply shone a spotlight on what was happening previously, with patients waiting to be seen for many hours in emergency department corridors.

I do not have any quick solutions on mitigating the issues with our workforce. Last year, we undertook a census that showed that, in Scotland, we are short by approximately 130 of the number of whole-time equivalent consultants in emergency medicine who are needed to provide the appropriate level of care, and to ensure that there are enough consultants for the number of patients that the departments see.

You are correct about the time that it takes to train a consultant; there is no quick solution. As Professor Elder highlighted, retention is the key. Our census showed, unfortunately, that one in every five consultant colleagues plans to take early retirement in the next five years, and one in two—50 per cent—plans to reduce their hours in the next four years. We currently have significant workforce challenges that will, unfortunately, only increase over the next few years.

Murdo Fraser: Thank you, Dr Thomson. I have one more question—I am happy to open it up to other witnesses to get their perspectives. You have talked about the importance of retaining staff. Anecdotally, we hear that there is a huge issue across the NHS with burnout among staff who have had to live through the past two years of Covid. That has probably accelerated the trend of people seeking to take early retirement. Is that your perspective? If so, what practical steps could the Scottish Government and the NHS take to encourage people to stay on?

Dr Thomson: Perhaps I can start. I have not seen a significant number of colleagues leave the specialty because of the pressures over the past two years. However, there are pressures not just in emergency medicine but throughout the whole health and social care system. Everyone is under the same pressure and is feeling the same degree of stress and intensity as a result of what has happened over the past two years, which has really just opened up to everyone knowledge of the issues that the NHS was dealing with prior to the pandemic.

Murdo Fraser: I think that Professor Elder was hoping to come in.

Professor Elder: Thank you—my microphone was muted. I have a couple of points to make on your first question. First, although our discussion today is focused primarily on the impact that the pandemic has had on mortality, we have to bear in mind the huge impact of waits at the front doors of our hospitals on other aspects of the quality of care that we deliver.

As you pointed out, it is alarming if waiting leads to excess deaths, but it is also tremendously detrimental to the overall wellbeing of patients and their families if patients have to wait to get properly—as they would see it—into the hospital. In our whole discussion, we must, although we are focusing on mortality, look at the impact of the pandemic in many ways.

Secondly, I will comment on international recruitment as a potential short-term supportive measure. I do not believe that we should disregard it, but there are a number of issues. You are correct that the medical workforce issue is a global problem and that there can be so-called ethical concerns about a relatively wealthy country like Scotland absorbing doctors from other countries that might not be so well placed.

However, we have to remember that training and experience in Scotland are still very highly regarded by international colleagues. The Royal College of Physicians of Edinburgh is an international college, so I hear that all the time from colleagues. A number of systems are available that can be developed to enable trainees, in particular, who can have a role in service delivery, to come to Scotland to work for short periods and then return home to their own countries. It is worth bearing in mind that many trainees in many large countries around the world—for example, India—cannot access high-quality training. We should not give up on, or disregard, international recruitment.

The second point was about staff retention. Anecdotally, from speaking to many colleagues, I hear that that is a great worry. That is not just about more senior colleagues who might have the option of taking early retirement. I worry that, as international travel opens up again, some of our trainees might start to look elsewhere to go and work. For many of them, that is about things such as their being respected and valued in the workplace, and about the messages that they hear from the media and politicians about how much they are respected and valued. It is about things including access to a place to rest and to hot food when they are on call. Recently, there was a story in the media about the accessibility, or otherwise, of period products in Scottish hospitals. There are some basic things that we need to focus on more in all our hospitals, which I suggest will make our trainees, just as much as our consultants, feel that

they are truly valued and, therefore, more likely to want to remain in our workforce.

The Convener: Thank you very much. We move to Alex Rowley.

Alex Rowley (Mid Scotland and Fife) (Lab): Good morning. I will begin by asking a question about availability of data. Earlier this week, we learned about waiting times. There are 680,000 people on NHS waiting lists, which means that one in eight Scots is on such a list. When it comes to data, is it possible to determine a relationship between a person's cause of death and whether they were on a waiting list? If we want to understand excess deaths, how do we understand the impact of people's being on those unacceptably long waiting lists? I ask Dr Miles to comment.

Dr Miles: That is not precisely the SICS's area of purview. Some people are on waiting lists for long-term chronic conditions, and some are on them for more acute conditions. Teasing out whether excess mortality relates to all people on waiting lists would be quite difficult. However, one of my surgical colleagues could probably comment on that in relation to certain surgical procedures, and the physicians could comment in relation to long-term health conditions.

Alex Rowley: Professor Elder, are you able to comment about the ability to collect data and understand the impact of those large—massive—waiting lists?

Professor Elder: First and foremost, I agree with Dr Miles that, particularly in the context of the pandemic, it would be very difficult to connect time on waiting lists with what we will call excess mortality. As I said at the beginning, we should not jump quickly to conclusions about that.

My next point will hark back to what I have just said. Although it is important to consider what you are asking—about whether a prolonged wait for an investigation or procedure increases mortality—those prolonged waits also have impacts other than on mortality. We all understand that if someone is waiting for, for example, a knee replacement, that is unlikely to lead to their premature death. It is possible, but unlikely. However, the person will have the burden of the disability and dependency that go along with having advanced arthritis of the knee, as well as the pain and suffering that go with it. There are drivers other than excess mortality that should make us push to reduce waiting lists.

09:30

Alex Rowley: The RCGPS's submission recommends that

"To increase the support and care that GPs and their teams can provide for those patients, mental health clinicians should be made available to all GP practices".

One of the reported outcomes of the lockdowns and two years of Covid has certainly been an increase in mental health issues. I have no doubt that GPs will have seen that. What is the current position in that respect?

Secondly, with regard to integration joint boards, is integration going right down to medical practices, with mental health, social work and other services all being available through them? Are we seeing that level of integration across Scotland, or is the situation patchy?

Dr Shackles: Thank you for interesting questions on those topics.

I have to say that provision of such services is patchy and has, unfortunately, probably became more patchy during the pandemic. It all started off with good intentions, but, some services ended up being withdrawn during the pandemic. My practice has a mental health worker who is very well used, but I am aware of other practices that do not have that service, which is to the great disadvantage not just of patients but of the GPs themselves. We need to increase that provision and ensure not only that it is embedded in practices, but that patients know how to access such services. After all, one of the other difficulties that we have is with patients navigating a route to services so that they can get them in a timely manner. That situation absolutely needs to improve.

I do not believe that we have good enough integration at health and social care level, so we need to work harder at that with our social work colleagues. That is one of the gains that we hope to make from GP cluster working, which was becoming more effective as GPs and their teams started to integrate and work better with social care and local authority colleagues. Unfortunately, the pressures of the pandemic have, rather, put all that on hold; we hope that it can be brought back again.

I will go back to the previous point about waiting lists. One of the difficulties that we have in general practice is that, with the increased number of people on waiting lists, we see people returning again and again either because their condition has been worsening with, say, the pain of their arthritic condition or because they have been deteriorating clinically. That is increasing the pressure on us. We are also trying to work out how best to prioritise patients who might need to be expedited and put higher up a waiting list. It becomes very difficult to get them back into the system. We do

not want to create a revolving-door situation in which we see only people who are on waiting lists. New people with new conditions are coming in, too. There is an increased burden on all services.

Alex Rowley: That is what I am trying to get at with regard to waiting lists—I am trying to understand what the impact is and how you measure it. On the example that you gave, I know someone who is on the waiting list for a hip replacement and who is in absolute agony, which is having a wider impact on their health. That has been made worse by one of their friends having been able to put together £15,000 to go away and have their hip replaced just like that. What I am trying to find out is how we as politicians and policy makers can understand the impact of one in eight people in Scotland being on an NHS waiting list.

Dr Shackles: What we absolutely need to understand is that we do not have good enough data in primary care on the types of people whom we are seeing, the appointments that we have, the workload and the available workforce. If we are to understand the situation, we need much more data about what we are seeing, whom we are seeing, the number of people with repeat consultations and what those consultations are for.

We can see from data from England that patients used to consult their GP three or four times a year at a maximum, but that is now going up and up; people are attending multiple times in a year, which puts an increased strain on primary care. Not only is the population increasing, but people are attending more often, to the extent that that might be becoming unsustainable. We need data about that in order to see whether we can help to reduce the need for attendances and get people treated more effectively, rather than their having to come back to us all the time.

At the moment, we absolutely understand that people are in pain and are concerned about their health. If they come back to us, we try to deal with them as best we can. However, we need more and better data.

Alex Rowley: I return to a point that Murdo Fraser was speaking about. Dr Thomson, my understanding is that it takes 11 years to train an emergency department consultant. I took the point that Professor Elder made about continuing to recruit from abroad. Given the pressures and the massive staffing shortages right now, is there any type of short-term activity that the Government should be undertaking to bridge the gap between the length of time that it takes to train a consultant and the problems that we have right now?

Dr Thomson: That is a difficult problem. I would echo some of the points made by colleagues earlier about widening the net and making it easier to recruit internationally. It is a large marketplace for doctors to work in. It needs to be attractive to come and work in Scotland, not just financially but in terms of working conditions. We have spoken about wellbeing, and Mr Fraser spoke about burnout. From an emergency medicine perspective, one thing that would improve the wellbeing of our colleagues is reducing the waits for patients in emergency departments. Improving the system and improving the care that we are delivering to patients is the main thing that would improve our wellbeing. It is not a matter of financial remuneration or improved terms and conditions; it is about seeing that the care that we are delivering for our patients is improving. That is an important point to make and to hear.

The situation is not solvable just from the front door from an emergency medicine perspective, as emergency medicine is part of a whole system. We see the patient at the start of the journey of secondary care, but the whole system impacts on the delays that patients are facing.

Professor Elder: An additional angle on the workforce issue involves considering the role of the consultant. We have aimed—quite rightly, I believe—to have a consultant-delivered service, rather than a consultant-led service. I have already said that trainees contribute a lot to the service, but it has been an aspiration for very well-trained doctors, with a long time of training, to be heavily involved in service delivery.

I do not think that it would be correct to move away from that philosophy, but we must consider what aspects of the work of both the hospital doctor and the community doctor can be delivered by other healthcare professionals. That is already well established and is happening.

To answer your question specifically in the context of my own physicianly background, the physician assistant movement and the development of that profession will help to bolster the medical workforce and to deliver some of the services that have traditionally been delivered by consultants.

Dr Miles: Just to go back to some of the points that Professor Elder and Dr Thomson made, making Scotland an attractive place to work is not all about remuneration; it is about making people feel valued in the workforce. Quite a lot of work has been done on what affords staff wellbeing, and some of those matters could potentially be addressed in the short term.

We need to consider what makes a staff member feel valued in the workplace and what will aid their retention. Those are not always difficult things to achieve and can include better transport links, providing rest areas, more parking and hot

food. Those things can potentially make staff feel that their workplace values them.

Developing allied health professionals to fulfil some of the roles that medical staff do will be helpful, but it often denudes other parts of the workforce. Many allied health professionals are nurses and, when they are trained to become advanced nurse practitioners, that denudes the nursing workforce of skilled, experienced nursing staff. It could therefore help one area of the workforce but cause issues for another. However, we would all find it helpful to expand medical working and reduce the workload on consultant staff.

Dr Shackles: I concur with Dr Miles's points about workforce wellbeing. We think that those things are essential to retain the workforce and make it attractive to work in Scotland. We are pleased about the workforce specialist service, which is available to help look after healthcare workers' wellbeing and mental health.

However, we have general concerns about the level of abuse that has been levelled at GPs and their staff. A British Medical Association survey that was carried out at the end of last year showed that about 88 per cent of practices reported verbal or physical abuse being directed either at GPs or at members of staff during the previous month, and that is unacceptable. Our staff do their best for patients and the public, but we cannot magic up appointments and resources where we do not have them. It is unacceptable for staff to be abused. Events like those have a significant impact on people's retention. People say that they do not want to do their job any more if that is what they will be subjected to.

Some of the narratives propelled both in the media and, occasionally, by politicians do not help that. In particular, the narrative that was circulating throughout the pandemic that general practices were closed was not helpful. Despite media activity by Dr Carey Lunan, one of our previous chairs, that narrative continued to persist. The abuse that we and our staff got sapped morale and had a big impact on how we work and on what people look to do in future. We need to change it.

Dr Thomson: I echo the points that my colleagues made about making it attractive to work in Scotland.

Dr Miles mentioned hot food. In a number of hospitals in Scotland, those working overnight do not have access to hot food or drinks. That is absolutely unacceptable for colleagues' wellbeing.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Thanks very much to witnesses for coming along to speak to us today.

I will come back to the issue of staff morale in a minute or two, but I will start by telling you what my thinking is. This is an inquiry into excess deaths. What do you feel the value of the inquiry is to your profession?

Dr Shackles: That is a good question at this time when we have all—as professionals and members of the public—been through a once-in-a-generation event.

As doctors and medics, one of the things that we value is evidence; we consider what has happened to us and then draw conclusions. We then see whether we can make changes and choices for the future. Considering that issue in depth is important. As Professor Elder said, it might take some time before we can learn all of the lessons and consider all of the data, but it is crucial that we do that so that we are better prepared for future events and know how to deal with them better.

09:45

We also need to open up a conversation with politicians and the media, and absolutely with the public, about how best our health service should go forward. That should include where we put our resources; where we concentrate with regard to conditions that cause mortality or morbidity; how we manage our elderly and our care-home population; and whether we put our resources into hospital-based services or look at community-based resources. In particular, we need to look at whether we can increase the focus on prevention as a way of trying to manage our health in the future, in particular given our ageing population and some of the significant patterns that we have seen, such as dips in longevity. It is important that we have those conversations, and inquiries such as this are very important in opening up those topics.

Jim Fairlie: I go back to Dr Shackles—I will come back to Professor Elder in a moment.

Do you believe that the purpose and value of the committee's inquiry is that it can shine a light on the deficiencies that already existed?

Dr Shackles: That would be rather negative. We know a lot about what the deficiencies were, so going over old bones would not be helpful. We have to ensure that we look to the future, and think about how we can best look at the issues. Simply criticising what has happened in the past would not be helpful to our patients, or to us and our morale. We might have to look at and learn from the past, but simply going over it without any thought for the future would not be productive.

Professor Elder: We should remember that the pandemic is not over. We might have to apply the

lessons learned from the past couple of years—if we can learn those lessons—within the next couple of years, if we get another variant with a higher mortality rate than omicron appears to have.

I would be wary of suggesting—I am sure that Mr Fairlie did not intend to do so—that the pandemic is over.

Jim Fairlie: No—far from it.

Professor Elder: In this inquiry, we are looking way into the future. In terms of the value to the profession now, I have said already that the metrics that we choose dictate our policies. Looking at mortality alone is therefore not the best way to go about things. It is very easy to measure mortality but, as the committee will know, the things that can be counted do not always count, and all that.

Curiosity is fundamental to both clinical practice and science, so it is entirely appropriate that everybody is asking questions about these issues. However, we have had an extraordinary two years, with a major event, and it is entirely appropriate that we look at it now.

My final point is one that I have mentioned already. I sincerely hope that we—as a society, a political community and a medical community—have the real capacity to learn whatever lessons our experience has given us and take them forward, because that is not always the case. Some of the lessons from the pandemic in 1918-19 were writ large, but we did not apply them as well as we might have done.

Jim Fairlie: Thank you for your answer. You said that you hoped that I was not implying that the pandemic was over—it is quite the opposite. I am probably one of the more cautious people, given my background.

With regard to learning the lessons, and splitting up elective provision and emergency provision, would it be fair to say that, had we had elective clinics already in place, we would have had fewer excess deaths?

Professor Elder: Sorry—is that question for me?

Jim Fairlie: It is for anybody who wants to answer it. You guys are the experts.

Professor Elder: The amount of excess capacity that we would have had to have in order to cope with what was coming simply would not have been practical. No healthcare system in the world—or none that I know of—has the excess capacity available for its elective work that would enable it to prevent the displacement of activity that occurs with the kind of surge that one sees from a virulent virus. In theory, the answer is yes, but in practice, the answer is no.

As I mentioned earlier, and as you said, the pandemic has been spotlighting things that we knew already, but during every Scottish winter for the past 10 years we have seen the displacement of elective activity because of winter surges in urgent activity. That lesson can be carried forward into the idea of better separation of elective and urgent care.

Jim Fairlie: I will pursue that a wee bit further. There is a plan to build a 33-bed elective care centre in Perth. Had that already been established and up and running, the people in my constituency would have had access to it during the pandemic. It might not have reduced the excess death numbers, because we were losing people to Covid and related diseases. Nonetheless, would it have meant that we would have been able to treat people diagnosed with cancer at an earlier stage, rather than their being—for want of a better phrase—bumped down the line?

Professor Elder: As Dr Thomson said earlier, any new facility needs staff. We should remember that we were redeploying staff to provide support at the front doors of our hospitals. Had that facility existed, it would not have been able to do what you hope that it would have done, because we would not have had the staff.

The Convener: Dr Miles wants to come in on Jim Fairlie's question.

Dr Miles: I agree with much of what has been said. On Jim Fairlie's original question, the point of this inquiry and its value to the profession is to enable us to learn, and I hope that we can apply that learning to try to make our health service slightly more resilient. We could never respond to the peaks of activity that we saw in the first waves and subsequent waves, but we might be able to manage the peaks of winter activity more effectively as a result of what we have learned from the pandemic.

I agree that we do not have the excess capacity to enable us to manage the peaks that we have seen previously. We simply do not have the workforce. The only place where there is activity that could be stood down is elective activity, and people were mobilised from theatres and out-patient departments to help with the acute demands in in-patient facilities. That service was always going to be vulnerable. If we have on-going peaks, as Professor Elder said, that will happen to some extent, not infrequently, every winter. It is how we—

Jim Fairlie: Sorry—I want to come in on that. Surely it would not be viable for us to have that level of staffing at all times in order to cope with a potential peak.

Dr Miles: No, it is not viable, nor are there the staff out there to employ.

The Convener: Sorry, Jim—I am conscious of time, so I have to move on to questions from Brian Whittle.

Brian Whittle (South Scotland) (Con): In the evidence to the committee, I was struck by the suggestion that patients are now presenting with more acute conditions than they were pre-pandemic. I suppose that I could ask any of the witnesses about that, but I will start with Dr Miles.

Dr Miles: As a society, we do not have data on that, but there are anecdotal reports that people are presenting with chronically comorbid conditions that have not been managed as efficiently as they could have been under normal NHS working conditions. Patients are presenting more frequently to hospital with decompensated disease. There are some conditions that, if they are not managed under the elective programme, mean that people will, as has been said, present frequently to a service—the GP or the hospital—as the conditions flare up. There may be some data coming through on cancer presentations, but it might take some time for that to be interpretable.

Brian Whittle: I do not know whether any of the other witnesses wish to contribute. Professor Elder? It seems that everybody wants in. Professor Elder can go first.

Professor Elder: Since our written submission was made, I have been made aware of one paper in Scotland, which I could forward to the clerk if you wish, which considers what we call the acuity of presentation in patients in three centres across Scotland. Acuity was judged based on the extent of damage to the kidneys and some other changes in the chemistry of the blood, and also on early in-patient mortality. That paper is relatively small, but it is the only peer-reviewed evidence that I am aware of at the moment. As I say, I can make it available.

The strong anecdotal clinical impression is that the suggestion that you highlight is the case, particularly among colleagues who work in the specialties of diabetes, cardiology and oncology. If, by "acute", we mean how unwell someone is when they come to the hospital, we can separate that out into how advanced their disease is, particularly when presenting to the hospital with cancer. I would say that there is a strong, if anecdotal, impression from clinicians and from some pathologists that cancers are more advanced when patients present. However, we are going to have to wait for a longer time to get more information on that.

Dr Thomson: I would make the same point that Professor Elder has made: that there is very little in the way of published data on this. However, within the emergency medicine community, there is a clear consensus—although it is anecdotal—that emergency practices were dealing with patients of higher acuity. Although it is normal for patients to be diagnosed with cancer by presenting to emergency departments, a number of patients had significantly more advanced disease, as Professor Elder said. There is no data, but there is unanimity among clinical professional opinion about the acuity of patients over the past two years.

Dr Shackles: Like the others, we do not have the absolute data, unfortunately. Anecdotally, however, within general practice, including at my own practice, we have been seeing patients presenting at later stages, either with their cancers, because they did not present to us, or for other reasons. As Professor Elder pointed out, we have an ageing population with multimorbidity and, because we have not been able to do a lot of the routine chronic disease surveillance and monitoring, those patients have potentially had deteriorations that, when they have developed some other condition, have made them present in a more acute manner.

We can see some of those elements, as Professor Elder alluded to. Dr Bernie Croal from the Royal College of Pathologists has some good data, which I think he is planning to publish, about the use of laboratory services, which goes down to GP levels. We can see that there was a big drop in the use of laboratory services at the start of the pandemic, and we are just now starting to see the chronic disease, bloods and surveillance getting back to a more normal level, which will be helpful, as we can monitor our patients more effectively now. There is anecdotal evidence, but there is nothing that we can give definitively from general practice.

Brian Whittle: That is very helpful, as it sets up the direction of travel in which we were wanting to go. That concerns the collection and analysis of data. We did a lot of work on the Health and Sport Committee in the previous session, before Covid, on Scotland possibly behind the curve in our ability to collect data. When approaching a challenge, we must be able to quantify what the challenge is in the first place.

Is the Scottish Government collecting data or setting up indicators that are adequate to establish the extent of the health impacts that are not directly related to Covid-19? Is one of the points of learning that we need to take from Covid that we need to be better at gathering and quantifying data?

10:00

Dr Shackles: That is a good question. We need to collect more data and we need new systems to enable us to do that. We in general practice have been waiting for years for information technology reprovisioning—for systems that would give us greater ability to collect that data.

The Read coding system that we use in general practice is outdated. We need to move to SNOMED CT. That has happened in England but not yet in Scotland. That would enable us to better code the medical conditions that we see and to track them.

However, we need the workforce to be able collect all the data. Data collection in primary care, including in general practice, has been poor for years. We are working with the Scottish Government and with other colleagues to try to improve that, but that slow process needs to be accelerated.

Brian Whittle: Does any other witness want to comment on that?

Professor Elder: Doctors in general and scientists will always want more data. Data requires resource to collect it. A fundamental decision must be made on whether we direct resource to the collection of data or to other parts of our health service. Therefore, whether we need more data is a moot point.

From the perspective of the clinician on the ground, it would be more helpful to have the ability to join up the different datasets that we have, and to be able to access and apply that to our clinical practice. We live in an age of fantastic IT, but it is still the case in the NHS that we are not always as well served as we might be with that IT, to enable us to use the data that exists.

Brian Whittle: I will finish my line of questioning. You got to the point that I was hoping to get to, Professor Elder: the IT system that underpins the health service and the direction of the service is outdated. That has not just happened during Covid; we discussed the matter, before Covid, in the Health and Sport Committee. Given that we are the COVID-19 Recovery Committee, I want to explore whether we should invest in an IT system that covers the whole NHS and clinical system. That would give us an ability to better respond to a future pandemic and, more generally, to understand what is happening in non-Covid conditions. Should we do that? Dr Thomson, your hand went up quickly.

Dr Thomson: In terms of Covid recovery, yes, we should do that. However, we have also spoken about the workforce for data collection. From the perspective of emergency medicine, three different systems are used nationally—and different hospitals use different systems—but none of those speak to each other.

There is also the large problem of primary care systems not speaking to secondary care systems. Consequently, we in emergency medicine see patients but are unable to access primary care data, which impacts on our ability to treat patients appropriately.

The clinical team—including clinicians, physician associates and advanced nurse practitioners—spends a phenomenal amount of time inputting data into the system, because it is so clunky and dated. All that clinical time is lost to poor IT systems. If those were improved, that would increase the amount of clinical time that is available for patients. Therefore, IT must be a huge focus not just for Covid recovery but for the NHS to move forward.

Brian Whittle: I had actually written down a note about the interface between primary and secondary care being part of the solution.

You highlighted that there is no universal system for the NHS to access. Presumably, then, you would ask for exactly that: a system—even a multilayered one—that clinicians can access. That would have a positive impact on the ability to care.

Dr Thomson: Our continuing to ask questions of patients is a huge frustration among them. Their perspective is that, when they see a doctor, be that in primary care or in secondary care, we have complete access to their medical records. Nothing could be further from the truth. When it comes to improving how we look after our patients, our having seamless access to the patient's medical record—which is becoming increasingly electronic if not purely electronic—is absolutely necessary.

Dr Miles: I echo many of the points that Dr Thomson just made. It is frustrating when we cannot get access to information, either in other health boards or in other parts of the health service, when we are dealing with the patient in front of us.

More data is always useful, but we have to be careful. The volume of data is not always the issue; the issue is about collecting the right data and using it in the right way. If collecting lots of data is workforce intensive but sometimes not all that data is required, the choice of data for collection, and the ability to analyse it and then implement it, are very important. We must be smarter about that than people might have been in the past.

This session is to look at excess mortality, but, to go back to the points that we have made before, morbidity is important. Mortality is easy to measure but morbidity is harder. Lots of patients live with excess morbidity. That aspect is very

important to them and to their families, and it affects the way in which they live their lives and how they function in society. Therefore, data on morbidity is also useful to collect.

John Mason (Glasgow Shettleston) (SNP): Dr Miles's points about mortality and morbidity tie in well with my first question, which is for Professor Elder. I am not sure that I understood what you say in point D of paragraph 5 of your written paper:

"Consideration should be given to the relative priority of treatment for high morbidity-low mortality conditions (for example joint replacement for degenerative joint disease) and treatments for conditions with higher mortality."

Are you saying that we should put more emphasis on morbidity than on mortality?

Professor Elder: I am saying that consideration should be given to that. Amid the various choices that we make about priorities, and what the discussion is getting at, is whether mortality should be our main policy driver and how we balance that against what we currently call morbidity, which, for example, might be someone on a waiting list for a long time with a very painful hip or knee. I am not suggesting that one is more important than the other; I am suggesting that, if we have to take such steps to accelerate recovery, one option is for policy makers to make a call on that.

John Mason: Do we as a society put too much emphasis on avoiding death?

Professor Elder: With an ageing population, a case could be made that a time comes in an individual patient's life—this would be for them and not for us to determine on the basis of their age—that the style of treatment should focus more on their comfort, wellbeing and quality of life than on their longevity. In my experience, some individuals definitely begin to hope and wish for that. That is an individual decision. However, through initiatives such as realistic medicine, we need to enable patients and their families, care givers and doctors to discuss that.

John Mason: I will quote your paper again, although other witnesses might want to come in on the issue. Point B of paragraph 1 refers to the United States, and states that

"around one third of excess deaths may relate to non-COVID causes."

My question is a more general one. Are there any lessons that we can learn from the United States, or from some of our closer neighbours such as France, Germany or the Netherlands, about how they have dealt with Covid and whether they have dealt with non-Covid cases differently during the pandemic and so on? Professor Elder, can you start?

Professor Elder: The United States analysis in question is huge. It points to—I will put it in inverted commas—excess "non-Covid" mortality, and the conditions that have been noted are those most likely to feature.

As for whether we can learn from the United States, the fact is that the approach taken from state to state has been very different, and many states are still in much more difficulty than we are, particularly because of varying rates of vaccination. Moreover, the fragmented style of healthcare, with its public and private aspects, makes it very difficult to draw conclusions. I would therefore say no, I am aware of nothing in particular that we can learn from how the United States dealt with those aspects. I also do not know whether there is anything that we can learn from our European neighbours.

John Mason: Do any of the other witnesses know whether there are other European countries that we can learn from or that have done anything particularly well compared with us? I can see everyone shaking their heads. That is okay—I will move on.

The Convener: Dr Shackles wanted to respond to your previous question.

Dr Shackles: I want to echo Professor Elder's comments about realistic medicine and its utility, but I also want to cover some of the data-sharing issues that have been mentioned. At the beginning of the pandemic, we in general practice spent a great deal of time contacting our patients to construct advance care plans, the number of which went up fourfold compared with the number before the pandemic. That was very useful not only for data sharing; it also gave us the ability to have conversations with individual patients about their wants with regard to their care.

We are starting to see some emerging—and published—evidence about the importance of continuity of care in general practice. The ability to see the same general practitioner or nurse each time can significantly affect and improve things with regard to morbidity and mortality, but the only way in which you can manage such continuity is to have the workforce to do that.

We see continuity of care as underpinning what we do as general practitioners. Because of workforce issues and the need for rapid access to general practice, some ways of working have been eroded to the detriment of patient care. However, continuity of care is necessary, and we need to build on it as much as we can if we are to address, say, the morbidity of patients and have the time for those really important conversations about what patients want from their care. Are they a patient who wants to be treated at all costs, or are they someone who values being kept comfortable and

looked after, and for whom additional treatment is not in their interest? Those conversations are difficult, and we need to be able to share them across the interface to ensure that we all know the patient's wishes.

John Mason: That is helpful. I certainly remember that, when I was young, we saw the same GP every single time.

On a slightly different issue, the Scottish Intensive Care Society's submission mentions resources, which is touched on in other submissions. It says:

"The health service budget is finite and was under resourced given the demands even before the pandemic."

We have already mentioned preventative spend. Dr Miles, are you arguing that we as a society need to spend more on health? Assuming that we are not going to cut that money from universities or schools, are you arguing that that will probably mean higher taxes, or are you arguing that we should be using money differently and better in the health service?

10:15

Dr Miles: Where resources are allocated and how much tax is raised by the Government is generally a political rather than a medical decision. The question of how we utilise the resource that we are allocated has some degree of political will behind it, but there is a societal will, too. Going back to Dr Shackles's point, I think that the question is: what is it important for society to focus on? Even if we are able to raise more money, resources will always be finite. America spends more on healthcare per head of population than we do and it still has not been able to deliver the healthcare that it would want to or that its population would demand.

Money, therefore, is not the only answer but what we decide to spend it on is important, too. In subsequent years, it is possible that we might decide to refocus it more on preventative care rather than on acute care, but those are conversations to be had with society and the political parties as well as with the health service.

John Mason: I was not surprised to hear you say that it was a political question, although I should say that the statement that the health service is underresourced is political, too, and one of my jobs is to ask where you think the money will come from.

On a similar theme, I note that Dr Thomson's submission talks about the need for extra beds, but with regard to the concept of preventative spend, a lot of people would say that we should give GPs more money and chop it off hospitals. How do we get that tension right?

Dr Thomson: On the issue of beds, we have set out we feel is required to meet the current demands on secondary care. We also need to look at options other than hospital admission as well as at different ways of treating patients; for example, colleagues talked earlier about community-delivered care and whether that should be directed. We need to use resources effectively and not admit patients to hospital who can be managed in different ways, particularly closer to home.

John Mason: Dr Shackles, does there need to be a shift away from hospitals towards primary care?

Dr Shackles: I would say so. Throughout my career, every high-level report that has been issued has said that there needs to be more focus on care in the community and on care closer to people's homes, and less focus on secondary care, but all we tend to see is money gravitating towards hospital services, whether that be the building of hospitals or increasing consultant numbers, and less being delivered in the primary care sector for the GP estate and GP surgeries and practices. One of the biggest problems that we had was delivering care in a Covid-safe way, because GP surgeries were not fit for purpose in that respect and did not have the space or work flow to deliver it effectively. That was a big strain, and it was caused by underinvestment in the GP estate and premises. I therefore think that things need to be rebalanced.

Equally, though, I agree with Dr Thomson that the number of acute beds available to us is probably not sufficient, and the question is how we square that circle. When I started my career, every general practitioner was 0.7 of a consultant; it is now the other way round, and we have an inverse pyramid with regard to the number of doctors working in the secondary care sector. That seems strange to me, given that all the policy makers are saying that care should be closer to the patient's home.

If we are going to look after more people at home, we will need more people working in the community. There are some initiatives such as hospital at home that involve hospital consultants and staff. That is all well and good, but other resources are required for that, too, particularly district nursing colleagues or social service carers who are needed to provide nursing care and potentially care in the community.

This is a complex issue—it is not just a case of doing one thing or another thing. That would be a massive oversimplification for a health service that relies on all of us working at the highest level to make it work.

John Mason: That was helpful.

The Convener: I will bring in Jim Fairlie. I cut you short, but I should not have done, because we actually had more time than we had thought. However, we really are short of time now.

Jim Fairlie: I will be very brief, convener. My question is for Dr Shackles. We all stood outside our doors and clapped for the NHS and for nurses, but there seems to have been a massive turnaround. You guys have now become the whipping boys, with GP surgeries experiencing appalling abuse. I guess that some of that will be because GPs' practices are changing and that you are now seeing people online as opposed to in person. Where is the GP system at the moment? Will it go back to being in-person appointments only? How do we make it easier and better for GPs as an individual profession within a wider profession? I very much take on board your comments about the tracing of patients' information, and we should look at that, as well as making sure that the IT system works for you guys. What else do you need to turn the situation around so that you no longer receive the utterly appalling abuse that you have been getting?

Dr Shackles: All the topics that you have raised are very much on our minds. Throughout the pandemic, in general practice, general practitioners and all our staff have done what we were asked to do. We applied the principal guidance that came down centrally from the chief medical officer, the Scottish Government and other agencies about public health and the way that we should be working. We have not made anything up ourselves—we have applied the guidance that we have been given.

We have been agile and switched quickly to the remote method of working that we were asked to do, while making sure that we could still see or visit those who were vulnerable and needed face-to-face appointments. That never stopped, but the message did not get through, partly because so many patients have been used to, over many years—their entire lives—just walking into their GP surgery.

Patients have had unbelievable access to general practice in Scotland over the years. When they were suddenly told that they could not have that access—that that had stopped—understandably, we got a reaction, particularly during the lockdown phases, when patients could not go out. If people cannot see someone working, they do not think that they are working. When they cannot see us, they do not know what we are doing.

However, our members have been working incredibly hard. As I said, they have been making up the advanced care plans, phoning our most vulnerable patients and working out the shielding lists. Then they started doing remote consultations by video and telephone, as well as making home visits to care homes, which never stopped.

As we started to open up a little more to patients coming into the surgery, demand went up and, inevitably, that demand exceeded supply, so patients were told that they could not speak to us or see us. We are still having initial conversations on the telephone, which uses up time and reduces the potential number of face-to-face consultations. We all try to make sure that we ask respiratory questions, so that we are not bringing people in who might infect those who are attending the surgery with Covid. Therefore, we are still working to the winter pathways as much as we can. That is despite Carey Lunan and others fronting public information films about the changes that we are making.

We do not believe that there will be a complete reversion to how general practice worked before. We always did some consultations by video and telephone. There will probably be a rebalancing. RCGP Scotland says that the balance will probably go to somewhere around 65 per cent face-to-face consultations and 35 per cent remote consultations. That might be appropriate, but there will be some areas where it is different, particularly in remote and rural areas, if patients, as they get used to them, find it more convenient to use new technologies.

However, patients still value face-to-face consultations, as do doctors, because they give us a lot of job satisfaction. That is one of the difficulties that we are seeing in relation to retention, because older doctors in particular are not enjoying the new ways of working. They do not get the same satisfaction from seeing their patients in those other ways. They are saying, "Do you know what? If that is what it is going to be, we do not want it". We must be very careful about that when considering recruitment and retention, because job satisfaction makes us work well.

We have been calling for better public messaging and for conversations with the public for a long time—well before the pandemic. We absolutely need that now, but the problem is that some of the damage has been done. People are feeling undervalued and abused, and we have to regain some of that trust. That does not mean that we undervalue some of the comments by patient organisations, such as the Health and Social Care Alliance Scotland. We understand some of the concern that patients have had, because they have not been able to access their GP face-to-face or at the time that they wanted. We understand a lot of their distress, so we need to work with our patient groups, to get a better understanding of that, because we can ensure that patients get seen when that is appropriate. However, a lot of those points are about

resourcing, as well as about the way in which we work.

Jim Fairlie: Thank you very much; that is very helpful.

The Convener: Thank you very much. I know that others wanted to come in, but, unfortunately, we have run out of time. I thank all the witnesses for their evidence and for giving us their time this morning. If witnesses would like to raise further evidence with the committee, they can do so in writing and the clerks will be happy to liaise with you in that regard.

I will briefly suspend the meeting to allow a changeover of witnesses.

10:25

Meeting suspended.

10:29

On resuming—

Ministerial Statement, Coronavirus Acts Reports and Subordinate Legislation

Coronavirus Act 2020 (Alteration of Expiry Date) (Scotland) Regulations 2022 (SSI 2022/40)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 4) Regulations 2022 [Draft]

Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Amendment Regulations 2022 [Draft]

The Convener: Under agenda item 2, we will take evidence from the Scottish Government on the ministerial statement on Covid-19, the two-monthly reports on the Coronavirus Acts, and subordinate legislation. I welcome our witnesses from the Scottish Government: John Swinney, Deputy First Minister and Cabinet Secretary for Covid Recovery; Professor Jason Leitch, national clinical director, who is joining us remotely; Dominic Munro, director of Covid-19 exit strategy; and Elizabeth Blair, unit head, Covid co-ordination.

Deputy First Minister, would you like to make any opening remarks before we move to questions?

John Swinney (Deputy First Minister and Cabinet Secretary for Covid Recovery): Thank you, convener. I am grateful for the opportunity to meet the committee, and I will make a brief opening statement.

On Tuesday, the First Minister set out to the Parliament the revised strategic framework. The "Scotland's Strategic Framework Update" document details the Scottish Government's approach to achieving a sustainable return to a more normal way of life while remaining prepared for potential future threats from Covid. That approach will support us to manage Covid effectively through sensible adaptations and public health measures that will strengthen our resilience and support our recovery as we build a better future. In time, we will seek to rely much less on legally imposed measures and instead rely more on vaccines, treatments and good public health behaviours.

We will continue to ensure the maximum possible availability and uptake of vaccination, in line with expert advice. Indeed, from mid-March,

we will start issuing vaccination appointments to all five to 11-year-olds. We will also begin providing an additional booster to care home residents, those aged over 75 and those aged over 12 who are immunosuppressed.

Testing has been, and will continue to be, a vital part of our management of Covid. Over time, and in a careful and phased manner, it is reasonable to move away from mass population-wide asymptomatic testing toward a more targeted system that is focused on specific priorities. We will publish a detailed transition plan for test and protect in March, by which time we will hopefully have much-needed clarity from the United Kingdom Government on testing infrastructure and funding.

From Monday 28 February, the guidance on how often to take a lateral flow test will change. We will revert to the advice to test at least twice a week, particularly if going to a crowded place or meeting anyone who is clinically vulnerable.

The updated strategic framework sets out a number of additional proposed changes to public health protections during the coming weeks. First, from Monday 28 February, the Covid certification scheme— which requires certain venues to check vaccine status—will end. Although the app that supports the scheme will remain operational for businesses that want to use it voluntarily to reassure customers.

Secondly, from Monday 21 March—assuming that there are no significant adverse developments—the legal requirement to wear face coverings in certain indoor settings and on public transport will end. From 21 March, we also expect to lift the legal requirement for businesses, places of worship and service providers to have regard to Scottish Government guidance on Covid and end the requirement to retain customer contact details.

The strategic framework details the kinds of behaviours and adaptations that will be encouraged in different circumstances, which include: enhanced hygiene, improved ventilation, increased hybrid and flexible working and face coverings in some indoor places. It is now less likely that those measures will be legally imposed in the future, but we will advise their use for as long as they help to control the virus and protect those who are most vulnerable.

The approach that is set out in the strategic framework will support us all to return to normality and ensure a safe and sustainable recovery.

I am happy to answer any questions that the committee might have.

The Convener: I will ask the first question. First, I thank the Scottish Government for the revised strategic framework that was announced this week. The lifting of restrictions later next month is welcome news for many.

There is currently uncertainty regarding the future of testing, but as our framework identifies three broad threat levels—low, medium and high—if testing is reduced in capacity considerably, how will it be possible to monitor outbreaks of new variants to determine what threat level we should be at?

John Swinney: My officials will provide further detail on that, but that is a material issue. An on-going level of testing infrastructure will be involved, and that is the key point that I want to reassure committee members about.

We cannot simply turn off testing, and it would be a mistake to do so. There has to be a mix between measures such as the Office for National Statistics infection survey, which is absolutely critical for intelligence purposes on the prevalence of the virus, and levels of testing that enable us to reliably gather the basic information that enables genomic sequencing to be undertaken so that we can identify any new strains or variants. We will consider that as part of the testing plan.

There has to be a degree of on-going intelligence about the prevalence of the virus in our society to enable judgments to be made about what stage we are at, and more detailed testing will be required to enable us to form a picture of what, if any, new strains are emerging in our society. There are almost two different elements and requirements that are necessary in that process to inform our judgments about the state of the pandemic and for us to be able to contribute to the international effort to identify any new strains or variants, which it is our absolute duty and obligation to participate in. If there had not been good international co-operation with the authorities in South Africa and good testing infrastructure, we would have had less early warning of the omicron variant than we had.

I invite Professor Leitch and Dominic Munro to add anything on the judgments that will be made.

The Convener: Professor Leitch, I do not know whether you can hear me. I think that you are on mute.

Professor Jason Leitch (Scottish Government): I am not now—somebody turned me up. I just said good morning, that was all.

Thank you for allowing me to contribute virtually this morning. That has helped significantly with logistics. I appreciate that.

The Deputy First Minister covered it very well. We need testing for four reasons. We need it for surveillance; we need it so that we know what disease we are treating, so we have to test before we treat; we need it so that we know what is

happening in high-risk institutions such as prisons, social care homes and hospitals; and we need it to enable us to manage outbreaks, whether they are in a chicken factory, a school or wherever else. The question is how to do that.

The end point for all western European countries is the same: we will test less. You do not test for flu in your home, but we test for flu in hospitals. That is where we are all headed, and we hope to be headed there relatively soon, but we do not know if we are going there yet. That is why our advice to the Deputy First Minister and the First Minster was to maintain the testing regime as it is presently with one principal change, which is the removal of daily or every-time-you-have-a-social-event asymptomatic testing and a move to twice weekly testing, which is what we did before omicron.

We will continue to monitor the pandemic. Currently, our case level in the population is one in 25—that is, there are four positive cases in every 100 people—so we think that it is too early to remove the present levels of protection, given the risk to others that an individual might represent. This morning, for example, I heard about a wedding that was attended by 120 people, with 30 positive cases being reported within a few days of the event. Keeping the positive cases out of those events, cinemas, care homes and public transport is still a crucial part of our protection. However, as prevalence falls, we can adjust our testing regime. That is the advice that we will give as prevalence falls, but I am afraid that it is not showing signs of doing that very quickly.

Dominic Munro (Scottish Government): I do not have much to add what the Deputy First Minister and Professor Leitch have said. Coming back to the convener's question and putting it in the context of future threats, the two key parameters that we will need to know with any new variant are: how much more severe it is than the current strains that are dominant in Scotland; and how much more transmissible it is. Whatever the arrangements for testing that we have in place, which the Deputy First Minister and Professor Leitch have set out, we need to be able to ascertain those two things quickly. We need to ensure that our infrastructure, including targeted polymerase chain reaction—PCR—testing, waste water sampling and a sufficient ONS infection survey, enables us to get the kind of data that enables us to quickly ascertain severity and transmissibility.

The Convener: As I have already said, the announcement regarding the removal of some of the restrictions in March is very welcome, but a lot of people will have concerns, particularly our most vulnerable people—perhaps those who have been on the high-risk list during the pandemic. What measures will the Government take to ensure that our most vulnerable people at high risk still feel supported as we move on to the next stage?

John Swinney: That is a vital issue. I quite understand the appetite on the part of individuals to return to something like normal life, although there are some in our society who are frankly terrified by that prospect in the light of Covid. The first thing that we must do is be respectful of their views and concerns, and we must understand the anxiety that they face. That is why we have taken a gradual approach. We have tried to respond in a measured way to build as much resilience as we can within the population. Vaccination is critical to help us on that journey. Some people are vulnerable and cannot get vaccinated, for entirely understandable clinical reasons, which increases their anxiety further. Vaccination is critical to building resilience.

There are routine measures and, although we may remove the legal obligation to wear face coverings on public transport on 21 March, we will still be saying to people that it would be advantageous to wear them, and that it would a good civic gesture to protect other people.

We want to ensure that those who are very vulnerable have access to the clinical support that they will require. For example, individuals who are immunosuppressed have had communication from the chief medical officer that antivirals will be available to them because of their clinical vulnerability, which they should access. There is mental health support that we would want to make available to people to support them with their anxiety. In general, we want to work to ensure that people have the support that they require, recognising that the relaxation of restrictions is not universally welcomed within our society. We ignore the anxieties and fears of individuals in our society at our peril.

Murdo Fraser: Good morning. My first question is a neat follow-on from the question that the convener has just asked. We have now seen a move from the Scottish Government, announced by the First Minister on Tuesday, away from legal restrictions towards a situation where we are increasingly relying on personal responsibility and individuals complying with public health guidance. That is very much in tune with what has happened elsewhere in the United Kingdom. First, the Welsh Government announced that, then the Northern Irish Government, and the Prime Minister announced the same for England on Monday, albeit on slightly different timescales.

Is it now the assessment of the Scottish Government that the public are in a place where they will, in the main, comply with public health guidance without it being required to be set in law that they behave in a particular way?

John Swinney: That will be our general assumption in relation to the management of the pandemic, but we have to ensure that we have the legal and statutory capacity in place to respond to a deteriorating situation, should that be the situation that we face.

Murdo Fraser: Thank you for that response. We have seen from the discussion around the rules on self-isolation this week that the Scottish public have complied very well with the public health guidance. When the Prime Minister announced that the self-isolation rules for England would be dropped, a lot of criticism was made of him in some quarters, and some people seemed oblivious of the fact that, in Scotland, there has never been a legal requirement to self-isolate following a positive test, except in the very limited circumstances of international travellers. I think that we are in a good place in terms of the public.

The reason why I ask the question, as you can imagine, is that we have an instrument to consider shortly on extending the extraordinary powers that the Scottish Government currently has for a further six months. Given that we know that the Scottish public responds very well to public health advice, why can we not just trust people to follow the advice because we know that they will do so, rather than having those legal powers continue?

10:45

John Swinney: It is because we may face a deteriorating situation and might have to take some more severe action. I hope that we do not have to, but we might.

As I have rehearsed with the committee previously, on one Tuesday morning in November, the Cabinet thought that the pandemic was pretty stable and that we could look forward to a pretty straightforward Christmas, but 48 hours later Michael Matheson was on a call with the United Kingdom Government about applying travel restrictions on South Africa and various other African countries because omicron had descended on us. To be blunt, omicron was the variant of the virus that came closest to tipping over Scotland's national health service—it came very close.

That all happened in the space of 48 hours, so I cannot predict what lies ahead. However, I have sat in Parliaments for nearly 25 years, and I have listened to members of Parliament demand—rightly—that the statute book be capable of dealing with situations that we face. At this moment, given all the history of the past two years, I simply want to ensure that Scotland has a statute book that can be used, if it needs to be, to protect the public. I stress the word "can"—it can, not must or will, be used.

I suspect that I might be exposed to a good amount of criticism for not foreseeing this or that. In this particular situation, the Government has decided to try to foresee some of the difficulties that we might face and put in place a statute book that gives us the ability to respond in a way that we hope that we do not have to, but we may have to.

Murdo Fraser: I suspect that we may have to agree to disagree on that particular point.

John Swinney: I suspect that, on that particular theme, we may just have to.

Murdo Fraser: I have time for one more question. This morning, I was looking at statistics from the Office for National Statistics that suggest that, although there is a downward trend for infections across the rest of the UK, that is not the case in Scotland. The latest figures seem to show that we have an infection rate in Scotland of one in 20, whereas it is one in 25 in England and one in 30 in Wales. That would seem to suggest that, despite the fact that we have had more legal restrictions in Scotland over the past few months in comparison with other parts of the UK, in particular England, that has not had a beneficial impact on the case rate.

As I am sure that you have seen, there was a study in the *Financial Times* two weeks ago that analysed the figures for the past six months. It suggested that, again, despite the fact that there were more restrictions in place in Scotland, including a requirement to wear face masks in certain settings, there was in fact no beneficial outcome. In fact, the *Financial Times* suggested that the rate of death in Scotland from coronavirus was higher than in the rest of the UK. Does that not suggest that the Scottish Government's approach of having more restrictions has not delivered better outcomes than elsewhere?

John Swinney: No. I am, obviously, aware of the ONS infection survey data from this morning. If my memory serves me right—I stand to be corrected on this—this is the first week of the survey, certainly since the onset of omicron, in which the incidence ratio in Scotland has been at a poorer level than elsewhere in the UK—that is certainly the case in comparison with England; the situation may well be different with regard to some parts of Wales, where there have been restrictions in place. This is the first occasion on which that has been the case.

The *Financial Times* assessment raises a lot of questions because, essentially, the death rate in Scotland—I hate to talk in this kind of language, but the question has been put to me, so I have to do so—has been comparatively lower than the death rate in England throughout the pandemic. I

am not quite sure where the *Financial Times* gets its conclusions from.

It is important that we take measures that we consider to be proportionate and appropriate. The Scottish Government has done that throughout with the objective of protecting the public. If the position in Scotland had been any more serious than it was—and it has been serious—I am sure that many people would be queueing up to demand that the Scottish Government take even stronger action than it has done. Indeed, some people have demanded that.

People are free to make those arguments but we have to make balanced judgments. Protecting the public has been at the heart of those judgments.

Murdo Fraser: I would love to pursue those issues further but I fear that we are out of time.

John Mason: We continue to have a problem with misinformation and people who are Covid sceptic or vaccine sceptic. I understand that some of the data that has been produced has been misused, misquoted or twisted and, as a result, Public Health Scotland will not continue to publish some of the figures. There was an interesting article by Helen McArdle in Saturday's *Herald,* which, to be frank, I struggled to understand. Will you clarify what the problem was? I think that it might have been to do with how the unvaccinated population is counted. Will you clarify why the data is not solid and why it is not being published?

John Swinney: I invite Professor Leitch to come in on that point, or we might have to write to the committee on it.

Professor Leitch: I am not entirely clear what the issue is, so writing to the committee might be the best idea.

My best—I was going to say "guess", but you should never say "guess" in front of the Deputy First Minister or a parliamentary committee. My best thinking on that is that one of the translational challenges in the vaccinated and hospitalisation data is working out why it looks as though more vaccinated people than unvaccinated people are in hospital. It is a good question. The reason why is that the vast majority of people in the country are vaccinated. Therefore, we still end up with more vaccinated people in hospital because our denominator is so huge compared to the small numbers of unvaccinated people.

However, if we look at the proportion of vaccinated people who end up in hospital compared to the proportion of unvaccinated people who end up in hospital, we see a stark difference. That shows globally that vaccinations stop hospital admissions, ICU admissions and deaths. They do not stop them in their tracks, of course. They do not reduce them to zero, but they reduce them significantly. Therefore, when you go to intensive care—as I did this week at the Queen Elizabeth university hospital—you are proportionately much more likely to see unvaccinated people in the unit.

I will look at Helen McArdle's article and we will get back to you on the specifics, but I imagine that that is what the issue was.

John Mason: I think that that is the area that article touched on. There was also mention of ghost patients. I understand that the population of people who are registered with a GP is higher than the population as a whole.

John Swinney: Yes, that is correct.

John Mason: That seems to be another part of the issue.

John Swinney: Mr Mason will understand that, although I try my best to keep abreast of newspaper articles, I do not read every one of them. If that was the case, I would do nothing else in life. If the committee will forgive me, we will write to the convener with a response on that point.

John Mason: That is fine. Professor Leitch's answer dealt with the problem. It is helpful to get it on the record.

We are expanding the vaccinations slightly and some people are getting a fourth dose or second booster. Will you give us an indication of where that might be going? Will we go right through the population again from the oldest to the youngest or will annual boosters wait until the autumn for the under-75s?

John Swinney: I am again speculating, but the advice that we have received from the Joint Committee on Vaccination and Immunisation will result in us issuing vaccination appointments to all five to 11-year-olds very shortly. We will start issuing them in mid-March and do most of them around the Easter holidays. Additional boosters will be provided to care home residents, people who are over 75 and people who are over 12 who are immunosuppressed. That activity will dominate the spring and the period towards the summer. That probably makes it likely that we are heading towards a booster programme in the autumn, but we will await JCVI advice on that particular question. Assuming that there is no substantive deterioration in the situation, I think that we will be moving into a period when we will be relying on vaccination to provide us with effective resilience.

John Mason: My next question is on testing, which has been mentioned already. If we do not get funding from the UK, or if the UK does not fund the testing kits and so on, will that seriously curtail what we can do?

John Swinney: Obviously, we have judgments to make about the nature of the testing programme that we can take forward. That is informed by the decisions that are taken by the United Kingdom Government. Clearly, the financial arrangements that support an expansive testing programme will, if they are curtailed, have an effect on our ability to deliver such a programme.

We have to pursue the detail of the UK Government's announcement that was made earlier this week. It was pretty obvious that there had been a tense set of discussions within the UK Government—some might call it chaotic—which led to the announcements on Monday. That has not provided us with particular clarity about its intentions. We are now seeking that clarity, and that will inform the testing programme. I assure Mr Mason and the committee that the points that Professor Leitch and I put on the record in our responses to the convener will very much inform the formulation of the plan that the Government puts in place.

John Mason: On the strategic framework, there has been some mention of what we can perhaps do for Malawi, Zambia and Rwanda. Can you say anything about what we might do for them?

John Swinney: We are obviously working closely with the long-standing relationships that we have with those countries to play our part responsibly to support the vaccination programmes that are under way there. As a Government, we accept the importance of fulfilling our international obligations to ensure that the whole world is protected from Covid, because only by the whole world being protected from Covid do we have as much assurance and security as it is possible to have. Our co-operation will be to that end.

Brian Whittle: Good morning, Deputy First Minister and colleagues. I will take this opportunity to extend the conversation that we had with our previous panel about lessons learned and what we can do in the future. In most of the submissions that we had from experts, the word "anecdotal" appears a lot regarding the collection of data and what is happening, especially on what is happening with non-Covid-related conditions, and I note from the written evidence that

"deaths from other conditions may have increased",

although the Royal College of Physicians of Edinburgh is

"not aware of any published data to support this."

This is an extension of work that was done by the Health and Sport Committee in the previous session of the Parliament on collection of data. Fortunately, one of the experts speaking to us this morning raised the issue of the IT system that is currently available in the NHS, and words such as "clunky" came out. There are three different systems that the NHS works with just now. Looking ahead, I think that it would be beneficial if one of the investments that are made is to deliver an IT system that allows the proper collection and deployment of appropriate data. Covid has taught us that data is incredibly important.

I know that the Government was considering this in the previous session; I wonder where we are with the potential development of a new IT system for the NHS.

11:00

John Swinney: The first observation that I would make on Mr Whittle's question is that, in a sense, he has just echoed one of the fundamental points that I made in my response to Mr Fraser. It is important that we deduce lessons from the pandemic and, if they are important, that we learn from them and apply them. I happen to take that view about the statutory framework and Mr Whittle has put to me an entirely legitimate point about data and IT.

Scotland has been very well served by some critical decisions that were made a long time ago on the unique identifier—the community health index or CHI number—which has acted as the foundation for the administration of healthcare in Scotland based on the individual. It enables information on and records for an individual to be accessed appropriately to ensure that high-quality healthcare is delivered for that individual. That has been a strong foundation of our system but, of course, every development that comes along puts extra pressures on the core system. Covid has put many data demands on the system, particularly with regard to vaccination records and all that comes with such issues.

The Government has been taking active steps to ensure a strong approach to the delivery of digital care, and I think that it has got ever stronger over the course of the pandemic. What lies at the heart of the system is appropriate information technology capability to ensure that we can identify and meet the needs of individuals, and the Government will be working closely on that with health boards to keep the foundations of our IT system up to date and ensure that we meet the needs of individuals.

Brian Whittle: Healthcare professionals definitely vented some frustration this morning at the interface between primary and secondary care and the inability of secondary care to access primary care data when a patient re-presents. I worked in this area before my time in Parliament, and what interests me is how we get the ability to port that information and data. Covid has

highlighted and exacerbated the issue and, looking ahead and thinking about the lessons learned that you referred to, Deputy First Minister, I think that we have a very good opportunity to look at how and what data is collected and how it is accessed. That will require an IT system that is universally applicable to the whole of the country, which is not the case at the moment. Where are we with the development of that kind of structure?

John Swinney: I would want to look at exactly what circumstances the clinicians were raising with the committee this morning, but my understanding is that, throughout the health service, the capacity and capability exists to access critical information about the healthcare of each individual. That is why I referred to the CHI number, which underpins and drives the system. I want to understand a bit better some of the deficiencies that have been highlighted but, in principle, I agree with Mr Whittle's points about the availability of data and the necessity of collecting the appropriate data in our healthcare systems. I think it important to have a system that can be accessed in all different spheres of the health service. I am very happy to look at those issues and the particular points raised by the clinicians this morning, and I will encourage the health secretary to look at these questions and determine what further action requires to be taken.

Brian Whittle: I will finish here, convener, but I would encourage the Deputy First Minister and the health secretary to look back at the Health and Sport Committee's work in the previous parliamentary session. Listening to this morning's evidence, I have to say that the sort of universality of access that you have described is not the case in Scotland. If you input data in Glasgow, it cannot be accessed in Edinburgh and has to be reinput over here.

We are getting into an area here, but I think—it is not a criticism—that there is an opportunity to consider a system-wide change that would be to the huge benefit of our population and our NHS workers.

John Swinney: The characterisation that Mr Whittle puts to me is not my understanding of the situation, but I will go away and look at it again. There is accessibility for critical information, though perhaps not all information—I accept that—but I will certainly consider the issues that Mr Whittle raises and encourage the health secretary to do so.

Jim Fairlie: I reiterate what Mr Whittle has just said: the message that came across clearly this morning was that you cannot follow a patient regardless of where they are—the information does not follow them from one department to another. My understanding was that it could go right across the country but, from what we heard this morning, that is not the case.

There are so many things that I would like to talk to you about.

John Swinney: It is always like that. It is part of our relationship.

Jim Fairlie: I know. Given where we are in the pandemic, what is the World Health Organization's advice on testing?

John Swinney: I will turn to Professor Leitch to answer that point, but the World Health Organization's advice to us at this stage of the pandemic in general is to take care and not to think that everything is over and done with. The position that the Scottish Government has taken on, for example, the continued use of face coverings as a mandatory provision is in line with the guidance from the World Health Organization. The WHO will encourage us to maintain a testing infrastructure that enables us to identify what the prevalence of the virus is in our society and what we can contribute to international understanding of the virus by virtue of the information that we collect and the experience that we have.

In relation to specific measures and restrictions, the World Health Organization may set out what it thinks is desirable, but we as a Government have to judge whether that is proportionate, because we have to be satisfied that we could withstand legal challenge to any of the decisions that we take. Generally, however, the advice of the World Health Organisation at this pivotal moment of the pandemic is to take care. I turn to Professor Leitch to answer the specific question on the WHO's testing advice.

Professor Leitch: Very briefly, I will not go down the digital health tunnel, but I commend to the committee the October update to NHS Scotland's digital health and care strategy, which sets out the present position and plans for the future. The committee may want to consider that in deeper detail, and the Health, Social Care and Sport Committee certainly will.

Mr Fairlie, my four categories come directly from the WHO's advice. Mr Swinney is correct that the fundamental advice is that we should be cautious. The next variant—there will be one—will come from either a highly vaccinated country with a high prevalence, which is what we have, or an unvaccinated country. The virus will either find a way through vaccines—if it has high prevalence, it gets more opportunity to do that—or it will find a way of transmitting in an unvaccinated community.

The vaccine squeeze, which is what the virologists call it, is when the virus finds a way to infect new people. That means that we need to do surveillance, which requires genetic surveillance.

We need PCR testing for that. We need to do that, if we can, randomly across the country, like the ONS survey, but also for those with symptoms. We need to test in high-risk locations, we need to have the capability to manage outbreaks and we need to know who to treat, because as the therapeutics improve, we need to know who to give them to. It is a fairly basic clinical formula: does this person have Covid, so should I give them Covid medication, or does this person have something else, for which they would have different medication? In order to make that decision, clinicians need testing. Traditionally, we do that once people reach healthcare.

The challenge with the disease that we face is that many of the great therapeutics that we are now developing are helpful before you reach healthcare and before you are sick enough to need traditional medication. It may be that antivirals could stop the heart transplant patient or the 85-year-old reaching healthcare at all. Therefore, we need to move testing up the chain and do it earlier so that we get treatment options. That is what the WHO says we should do and that is the advice that we are giving to the Scottish Government.

Jim Fairlie: The point that I am trying to get to is this: how do we surveil to ensure that, if a virus is moving about in our community, we catch it as early as possible? We know that the current system is sufficient. Will what we are moving to be sufficient?

John Swinney: Those are the discussions that we are having as part of the formulation of the testing transition plan. It has to be accepted that we cannot sustain the level of testing infrastructure that we have had in place for most of the past two years but we cannot have none in place.

There is a really interesting global point on one of the lessons from the start of the outbreak. Many of the Asian countries have been able to withstand Covid to a greater extent because, due to their experience of the severe acute respiratory syndrome-related viruses in the past, they have always maintained a much greater testing capacity and capability than was ordinarily the case in western countries. We might not go to those levels, but we certainly have to go some way towards them to maintain surveillance, so we have to have a debate on sufficiency.

We believe that a sufficiently credible and capable ONS survey is vital to enabling us to be properly prepared. We must have a level of testing infrastructure that enables us to detect and identify any new strains and we must have capacity to identify any emerging issues within individual populations. For example, Dominic Munro made a point about waste water sampling. It is a good way of determining the parts of the country where there might be, comparatively speaking, more incidence of the virus. The Scottish Government will sustain such sampling on an on-going basis.

There is not a definitive answer to Mr Fairlie's question today. It is an important and legitimate question. Over the next few months, we will have to find a satisfactory answer to the question of what level of capacity we should retain.

Jim Fairlie: I will ask one more very quick question, if possible.

The Convener: I am sorry, Mr Fairlie. We are running out of time. We move to Alex Rowley.

Alex Rowley: There is a thing called political balance.

It is not unreasonable to look for an extension of the powers for another period of time, given where we are, Deputy First Minister. If you were saying that you wanted the powers for ever more, that would be a different matter. That is why I welcome the announcement that work will be done on future pandemics.

Professor Leitch talked about possible variants. I worry that we are starting to get to a point where everybody thinks that the pandemic is over and we can get back to some kind of normality.

On the reports that are coming in the spring, are you considering a proposal for how we prepare and plan Scotland-wide? You say that you are talking to local authorities. Are we looking at regional approaches throughout Scotland so that we are prepared at a regional level?

Part of the evidence that we heard this morning from the Royal College of GPs was that, seven years on from the incorporation of health and social care into the integration joint boards, it is hit or miss at the local level as to whether services such as mental health and social work are joined up and working at the GP level. It is fine to have big, central plans, but we do not seem to be able to get them through on the ground and put in place a decentralised system of governance that delivers.

11:15

John Swinney: I am grateful to hear that Mr Rowley has taken his usual rational and considered approach to the regulatory infrastructure. [*Laughter*.] I welcome that and look forward to its being shared universally across the committee.

I very much agree with Mr Rowley's sentiment that there is a danger of people thinking that Covid is all over and done with. It is not. I know that I sound like a broken record with my omicron example, but these things can happen quickly. As international travel takes off again, we do not know

how quickly Covid variants might be able to spread across the world. It is absolutely legitimate to make that point.

On the preparedness question, Mr Rowley is correct. We are undertaking further work on future pandemic preparation. That has to be an all-Scotland approach, although that is not to say that the work must be done only at national level. It must be an all-Scotland approach that involves our resilience partnerships in every part of the country. From his long experience in Fife, Mr Rowley will be familiar with the local authority's role as a key member of the resilience partnership at local level, where it works with the health board, the police, the Scottish Fire and Rescue Service and various other players. We rely on them—as we have done during the pandemic—to deliver an appropriate response. Indeed, we have relied on them in relation to stormy weather, too.

Those local resilience arrangements must be effective, so we must engage with those partners. I regularly meet the Scottish resilience partnership, which brings together the local resilience partnerships. We reflect on the current threats and challenges that we face, how we should respond to them and what learning we can apply in every part of the country. We undertake that work, and it is all valid because we should be focused on pandemic preparation.

If I was to reflect on the past few years, when we have conducted an annual stocktake of the resilience threats that face Scotland, a pandemic has always been right up there, but we sit there waiting for it to happen. Stormy weather, on the other hand, comes along very frequently, as we know, as do flooding and various other things. It is important that we have that foresight capability.

Mr Rowley went on to raise a fundamental issue that is relevant to the debate about a national care service. He is absolutely correct. He and I will agree that there are variations in the quality of the delivery of care around the country. The question is what we do about that. I would contend that the arrangements that we have in place currently do not provide assurance that every member of the public in every part of the country who needs care services is able to get services of sufficient quality to a sufficient extent. Following the research that was undertaken as part of the Feeley review, the Government's view is that that would be best addressed by the establishment of a national care service. Parliament will have extensive discussions on that within the foreseeable future.

I emphasise that I acknowledge the importance of every member of the public, regardless of where they live, being able to rely on the ability to get a quality experience from a quality care service.

Alex Rowley: This week, we discovered that one in eight people in Scotland are on an NHS waiting list. Earlier in the meeting, I asked the health professionals what data is available on that so that we can understand the knock-on effects. I think that, a few weeks ago, Professor Leitch told me that most of the data on that should be available.

I gave the example of two constituents who needed a hip replacement and were suffering as a result. One of them was able to get together £15,500 and go and get it done privately—they are now sorted—while the other cannot afford that. That is having a knock-on effect on their mental health and so on.

What are we going to do about the waiting lists? Is regional planning being done health board by health board? How will we get the waiting lists down? How will we address the knock-on effects that these unacceptable waiting times are having on people's health and wellbeing?

John Swinney: We have had discussions in this committee and across Parliament on countless occasions, and Mr Rowley has consistently questioned me on the impact on people of non-Covid health harms. Those questions are absolutely legitimate, and I would be the first to acknowledge that waiting lists are larger and longer than they were before the pandemic, but that is a direct result of the pandemic.

No health board in the country wants to put off tackling those waiting lists—they want to get into a position to be able to do so as early as possible. However, we have to be mindful of the presence and prevalence of Covid. Although we have seen a fall in Covid admissions to hospitals in general over the past few weeks, Covid admissions are unfortunately rising again, to our unease, as is the number of people in hospital with Covid.

I assure the committee—this is part of the NHS recovery plan, and it is inherent in the Government's investment in elective treatment centres—that we are anxious to expand the capacity to enable us to address the very issue that Mr Rowley fairly puts to me, so that members of the public who are suffering with pain and need a hip replacement, for example, can expect to have that treatment within a reasonable timescale.

Alex Rowley: Should we not be saying to each health board that they need to identify exactly what the demands are in their area and start to bring forward some kind of proposal for how they will meet those demands?

John Swinney: I contend that that is what the NHS recovery plan does. It focuses entirely on the issue of making up for the treatment that has been lost because of Covid. Each health board is under an obligation, in respect of the plan that it has had

to submit to the Cabinet Secretary for Health and Social Care, as to how it is going to go about doing that. We are keen to ensure that we make progress as swiftly and as early as possible on advancing that treatment.

The Convener: I am sorry—we have run out of time for this part of the agenda. That concludes our consideration of item 1, and I thank the Deputy First Minister and his officials for their evidence today.

We move to item 3, which is consideration of the motion to approve the draft Health Protection (Coronavirus) Requirements (Scotland) Amendment No 4 Regulations 2022. As members will be aware, we will take the motions on the other two instruments that are listed under agenda item 2 at a future meeting, once the Delegated Powers and Law Reform Committee has reported on them.

Deputy First Minister, would you like to make any further remarks on this Scottish statutory instrument before we consider the motion?

John Swinney: I think that it would help if I put some comments on the record regarding the regulations. The committee has on its agenda three SSIs and a motion to approve the Health Protection (Coronavirus) Requirements (Scotland) Amendment No 4 Regulations 2022. Those three instruments all put back the date on which the key coronavirus provisions would otherwise expire by default, and thus act to protect our ability to have in place any measures that are considered necessary.

The draft Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 4) Regulations 2022 amend the date on which the Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021 expire, from 28 February 2022 to 24 September 2022. If the expiry date is not changed, the baseline measures will automatically cease on 28 February.

Although we are starting to take steps to remove the baseline measures, regulations that were shared with the committee yesterday will remove the Covid certification scheme from the regulations. It is important that the other baseline measures can remain in place after 28 February to support our review of the baseline measures on the basis of the latest data. We expect that the other legal requirements will be converted to guidance on 21 March, but as the First Minister said on Tuesday, that is subject to there being

"no significant adverse developments in the course of the virus".—[*Official Report*, 22 February 2022; c 18.]

The draft Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Amendment Regulations 2022 amend the date on which the Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Regulations 2020 expire, from 25 March 2022 to 24 September 2022.

The directions regulations will continue to be reviewed every 42 days, as the regulations require. Keeping those regulations in place for a longer period of time will support local outbreak management of coronavirus. Local action to control or close premises or businesses at the centre of an outbreak can, in many cases, be the most effective and proportionate response.

The Coronavirus Act 2020 (Alteration of Expiry Date) (Scotland) Regulations 2022 extend the expiry date of five provisions within the UK Coronavirus Act 2020 for a further six months, until 24 September. Without the regulations, those provisions would otherwise expire automatically on 24 March, alongside the majority of the act's provisions. The provisions that are being retained for a further six months relate to: the remote registration of deaths and stillbirths; removing the requirement for vaccinations and immunisations to be delivered by or under the direction of a medical practitioner; powers for Scottish ministers to give either boarding or student accommodation directions that restrict access or confine occupants; the power for ministers to give educational continuity directions and to enable education and childcare provision to continue; and powers for ministers to make health protection regulations such as the Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021, which were mentioned earlier.

All those provisions are in the Coronavirus (Recovery and Reform) (Scotland) Bill, which is undergoing scrutiny by this and other relevant committees. The Government thinks that those particular provisions should be legislated for permanently from September 2022, should the Parliament agree to the alteration of expiry date regulations—that is, of course, a matter for separate determination by the Parliament.

The alteration of expiry date regulations have been made under the made affirmative procedure. At the time of laying, our understanding was that that was the only procedure available to us for the regulations. It has since come to our attention, after discussion among lawyers, that we could have used the affirmative procedure. Even with that understanding, however, we are assured that Parliament would have 40 days for scrutiny prior to the regulations coming into force on 24 March 2022.

I move,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 4) Regulations 2022 [draft] be approved.

Murdo Fraser: I will comment briefly, given the time and given that we have already rehearsed these arguments in the committee.

The draft regulations before us seek to extend the extraordinary and emergency powers for a period of six months. As I outlined earlier, I think that we are now in a place—as I think the Scottish Government has more or less conceded at this point—where, in future, we will increasingly rely on the good sense of people to follow public health guidance, rather than being required to act in particular ways by the law. I believe that the experience that we have had over the past two years shows that people respond very well to public health guidance. I suggest that it is not appropriate for the powers to be extended. I believe that we should test the good judgment of the Scottish people, who have thus far demonstrated in spades their willingness to comply with public health guidance. For those reasons, I oppose the motion that is before us.

Alex Rowley: At this point, I believe that it is proportionate and reasonable for the Government to make the extension. We should not take our eye off the fact that we are not through this situation by any means. The longer term raises a different issue, and it is an issue that this and other committees will debate, but I do not think it is unreasonable to have a six-month extension.

Brian Whittle: Deputy First Minister, I vividly remember your bringing the emergency powers to the chamber, and quite rightly you had universal support from across the chamber for those emergency powers, given the situation that you faced at the time. However, you and the First Minister have said that the powers would be used only if appropriate, that they would be kept for the minimum amount of time and that they would face parliamentary scrutiny as quickly as possible. I remember how quickly the emergency powers were brought into being, when they were brought before the Parliament and voted on.

As my colleague Murdo Fraser says, we are in a different time now. The Government should not hold such powers unless absolutely necessary. Given that you could bring the measures back before the Parliament and given that the emergency powers could be reinstated very quickly if required, along with my colleague, I will have to oppose the motion.

11:30

John Mason: In people's thinking, there is a little bit of a difference between what is law and what is just guidance. I was down in England last week, where the restrictions tend to be more based on guidance and, despite what Murdo Fraser said about people's good sense, people were not adhering to a lot of that guidance. Therefore, it is too early to lift the restrictions. I agree that we do not want the legislation to be in place for any longer than it needs to be, but it is a little bit too early to change direction.

Jim Fairlie: Because people sometimes just put their hands up and say, "No, no, we're not doing it any more," the Government must have the ability to say that something will happen because of whatever the circumstances are. We are far from being out of the pandemic. I know that I may be one of the more cautious members of the committee but, as far as I am concerned, until we are through it, we are not through it. Therefore, it is essential that the Government has the powers to take proportionate action.

The Convener: I invite the Deputy First Minister to respond to the contributions that have been made.

John Swinney: I acknowledge that there is a difference of opinion among members on the issue. There is a duty on the Government to have in place a statute book that enables us to respond to the circumstances that we face. Colleagues have indicated that there are likely to be challenges ahead for us. The measures that are in place have appropriate safeguards and there is no obligation to use them. The obligation for us as parliamentarians is to have in place a statute book that can respond to the challenges that we face.

To respond to Mr Whittle's point, I have heard the criticism of Parliament that we did not have the necessary legislation in place to deal with a pandemic. If we are going to prepare properly for pandemics, we must ensure that we have the legislation in place with appropriate safeguards. I reiterate the point that, although the provisions will extend the regulatory infrastructure that is in place, they do not oblige the Government to use it in all circumstances.

On the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 4) Regulations 2022, if we want to continue the legal obligation to wear face coverings on public transport and in public places to 21 March, it must be put into place today or it will fall on 28 February. Therefore, in that short term, I appeal to colleagues to support the regulations, which will be the subject of a vote. There are two other instruments that will be subject to discussion in due course.

The Convener: The question is, that motion S6M-03168 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Brown, Siobhian (Ayr) (SNP)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Rowley, Alex (Mid Scotland and Fife) (Lab)

Against

Fraser, Murdo (Mid Scotland and Fife) (Con)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 4, Against 2, Abstentions 0.

Motion agreed to,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 4) Regulations 2022 [draft] be approved.

The Convener: The committee will, in due course, publish a report to the Parliament setting out its decision on the statutory instrument considered under this agenda item.

That concludes our consideration of the agenda item and our time with the Deputy First Minister. I thank him and his supporting officials for attending.

The committee's next meeting will be on 3 March, when we will take evidence from stakeholders on the Coronavirus (Recovery and Reform) (Scotland) Bill.

That concludes the public part of our meeting.

11:33

Meeting continued in private until 11:37.

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