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Health and Sport Committee

Wednesday 17 June 2020

Session 5

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Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
17th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Connaghan (NHS Scotland)
Bob Doris (Glasgow Maryhill and Springburn) (SNP) (Committee Substitute)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Professor Jason Leitch (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Wednesday 17 June 2020

[The Convener opened the meeting at 09:00]

Covid-19 Scrutiny (Resilience and Emergency Planning)

The Convener (Lewis Macdonald): Good morning, and welcome to the 17th meeting in 2020 of the Health and Sport Committee. We have received apologies from Emma Harper, and we are joined by Bob Doris in his role as substitute committee member. All members should ensure that their mobile phones are in silent mode.

The first item on our agenda is an evidence session on Covid-19 resilience and emergency planning with regard to preparedness for the pandemic and how future outbreaks of coronavirus or other pandemics would be managed.

I welcome Jeane Freeman, the Cabinet Secretary for Health and Sport. She is accompanied by Jason Leitch, who is the national clinical director for the Scottish Government, and John Connaghan, who is the interim chief executive of NHS Scotland. Thank you for joining us.

In a moment, I will invite the cabinet secretary to make a short opening statement, after which we will take questions from members in turn. Due to the challenges of managing a virtual meeting, we will take questions in a prearranged order. Once each member has exhausted their questions, I will invite the next member to proceed. I ask members and witnesses to be succinct and, please, to give broadcasting staff a few seconds to operate the microphones before you begin to speak. Members—please indicate when you are on your final question. I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, and good morning, convener and colleagues. I am grateful for the invitation to attend the committee to discuss our resilience and emergency planning arrangements for pandemics and other emergency situations.

I start by recording my continuing thanks for the response and for the efforts of all those involved across many organisations in Scotland. Our combined approach to Covid-19 has been built on the planning and preparations that we have had in place for several years. Our response has been based on those plans, locally, regionally and nationally. Where there have been challenges in dealing with the new virus, the foundations of our resilience planning have allowed us to adapt our response arrangements where necessary.

Pandemic flu planning has been the highest national risk to Scotland, the United Kingdom and, indeed, the world for a number of years. Rightly, our planning has been for mitigating and preparing for that. However, Covid-19 is different. The new virus is an unprecedented global event, which has presented many challenges for nations across the world. Although it has not been an influenza pandemic, the principles of resilience planning have allowed us to deal effectively with areas that require similar responses to influenza. Where there have been unique issues with Covid, we have been flexible in adapting and managing our approach.

There are common planning elements for responding to pandemics. On workforce issues, there is planning for loss of staff who are affected directly or indirectly, and for deployment of staff, including plans to manage how staff can be deployed and use of retired staff or volunteers.

On healthcare services, there is planning for reconfiguration of services and pathways to cope with anticipated patient demand. There is demand and capacity planning, and prioritisation of services to release capacity.

On the supply chain, there are contingency arrangements to ensure that supply chains are not disrupted.

A communications strategy sets out robust plans to ensure effective and proactive communication and engagement with staff, partner agencies and the public.

There is planning for partnership working and command control and co-ordination to ensure that emergency incident response structures are in place, and that roles and responsibilities are set out and clearly understood.

Those are all key elements of pandemic planning, and I argue that we have seen all those in our response, and that they have stood us in good stead. Those elements also correspond with the World Health Organization checklist on pandemic planning.

We have required a flexible approach to treating Covid patients in national health service facilities. We have made several important interventions to quickly remodel service delivery, including quadrupling our intensive care unit capacity and erecting NHS Louisa Jordan hospital. I am pleased to say that at no point has our NHS been overwhelmed, which is testament to the efforts of everyone involved.

However, the pandemic and its challenges are not over. I hope that the committee appreciates, as I do, that, when faced with a new emergency such as Covid, we need to learn continually how to deal with it. We are on a journey that is likely to last a considerable time and which requires continued and extensive effort.

Lessons have already been learned and implemented, such as in the supply and distribution of personal protective equipment across health and social care. We recently introduced a lessons-learned process for regional resilience partnerships and their member organisations to capture key issues, share good practice and, ultimately, help to shape future planning and preparation, including for the possibility of a second wave.

Challenges remain, not the least of which is how we respond to the non-Covid health harms that have been created by our necessary response. Addressing those while retaining Covid response capacity is a major part of our focus, at this point. The committee will be aware of "Re-mobilise, Recover, Re-design: the Framework for NHS Scotland", which was published on 31 May. The framework outlines how NHS Scotland will work to make the necessary changes to safely restart as many aspects of our NHS as possible, while considering the possibility of a second wave and necessary winter planning.

Our emergency and resilience planning have helped to mitigate the impact and consequences of Covid-19. As a Government, we remain committed to protecting the people of Scotland from the disease, and we will continue to work collaboratively with our partners in Scotland, with other UK nations and globally to minimise the impact and consequences of Covid-19, as well as other diseases and emergency situations that might arise, be they environmental disasters or acts of terrorism.

Convener, I know that the committee's public consultation in preparation for today's session raised various issues and that members will have many questions, which I look forward to answering. Thank you.

The Convener: Thank you, cabinet secretary. I will start by asking about some of the work that has been done over recent years to prepare for an event such as this pandemic. We are aware of operation Silver Swan, which we have spoken about with you before; operation Cygnus, which was sponsored by Public Health England, but in which the Scottish Government was a participant; and exercise Iris, which was conducted to look at a potential middle east respiratory syndrome outbreak in Scotland.

There were 13 recommendations in the summary of actions following exercise Iris. To what extent were those actions followed up? I am particularly interested in the recommendations to consider the feasibility of community sampling for high-consequence infectious diseases, and to ensure that health boards have considered the resource impact of contact tracing. Can you speak about those recommendations in particular, as well as about implementation of the recommendations generally?

Jeane Freeman: As you said, exercise Iris identified 13 action points, which covered guidance, specialist facilities, provision of PPE and contact tracing. The Scottish health protection network has been leading work to follow up on the actions from the exercise as part of wider work on preparedness for high-consequence infectious diseases.

As you will recall, initially Covid-19 was designated as an HCID and was later de-designated. The work of the health protection network included setting up an HCID sub-group specifically to look at preparedness for managing such diseases. The membership includes public health professionals, microbiologists, infection control professionals, epidemiologists and pharmacists and involves Public Health England. A number of areas of work have been completed. I will not use up time going through those, convener, but I am happy to send you a detailed list.

In 2017, the then deputy chief medical officer for Scotland, Dr Gregor Smith, wrote to local authority chief executives, NHS board chief executives, health and social care partnerships, resilience partnerships, resilience officers in local authorities and the health service and NHS pandemic flu co-ordinators, about a range of issues that needed to be followed up. He attached a list of actions across those recommendations that were either on-going—for example, on personal protective equipment—or which had to be completed by March 2018. Many of those actions have been completed; again, I am happy to provide you with the details.

Another piece of work, which was about to begin but has been paused because of the pandemic, is a set of further recommendations from Sir Lewis Ritchie. Those recommendations will be picked up as we progress in dealing with this pandemic and look partly at lessons learned and partly at ensuring that some of the recommendations, and the additional recommendations from Sir Lewis, are followed up.

The Convener: I am glad that Dr Smith wrote to local authorities and health and social care partnerships. Looking at the exercises in the round, it strikes me how little involvement there

was from bodies that are responsible for social care. For example, one of the scenarios suggested that social care colleagues might usefully be included in the command and control structures of health boards for responding to a pandemic. Has that been followed up, and what structures are in place to include in the key day-to-day decisions those who are responsible for social care?

Jeane Freeman: Health and social care partnerships are not designated as first or second responders in the Civil Contingencies Act 2004, which governs the overall structure of the resilience programme for local, regional and Scottish resilience partnerships. However, for Covid-19, they were actively involved in local resilience planning, which flowed from Scotland-wide resilience planning to regional resilience planning to local resilience planning and back. Therefore, although they are not legally designated to be involved in the groups, they have been involved in the resilience planning for the pandemic, and that will be one of the lessons to be followed up in future resilience planning.

The overall structure for resilience planning will ensure that our HSCPs are built into that framework, because, along with local authorities, they have played a key role in practical terms in a number of our responses, not least in the PPE hubs as well as in relation to the practical support for individuals who are shielding to help them to follow the guidance that we have issued.

The Convener: I look forward to receiving some of the detail that you mention. One of the Iris report recommendations was in relation to the Scottish Government resilience unit—indeed, all the exercises referred to it, particularly in areas such as—[*Inaudible.*] Has the role of the Scottish Government resilience unit changed in any way since 2018?

Jeane Freeman: The role of our resilience unit has strengthened over that time in the sense of its being a core of expertise and knowledge about resilience planning for a number of different emergencies. The Scottish Government resilience room was activated on 29 January and has met frequently since. When it was activated, it was chaired by the First Minister. The Deputy First Minister has chaired it on one or two occasions, and the First Minister has chaired it ever since. I have attended all the meetings.

09:15

Our planning for Brexit—and for a no-deal Brexit—has contributed to the expertise of the unit and helped our learning, and that has assisted with the cross-Government response. The health service was, of course, the predominant responder to the Covid-19 pandemic in the initial stages, and it remains a lead responder. However, we have always been conscious of the importance of other parts of Government and local government initially being aware of potential consequences and planning in anticipation of those, and then having increasingly active engagement in resilience planning for the economy, communities, the impacts on particular vulnerable groups and so on.

The Convener: Thank you, cabinet secretary.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, cabinet secretary. In the Silver Swan report, the Scottish Government acknowledged that a global pandemic would represent the single most disruptive event to face Scotland. The current acting CMO, Dr Gregor Smith, led a follow-up meeting to the exercise on 6 December 2016, at which delegates from across Scotland told your Government that

"resource pressures and competing priorities were having a significant impact on the ability to properly plan and prepare for a pandemic."

Was this feedback passed to your Government, and, if so, what did you do about it?

Jeane Freeman: Undoubtedly, the feedback would have been passed to Government, and it would have been factored into how we attempted to manage resource pressures and priorities. Clearly, planning for a pandemic is important. The core elements, which I outlined in my opening statement and which match the WHO checklist, were in place. We can see from our experience so far that many of those elements have stood us in good stead—not least, stockpiling of PPE by our national procurement and supply service and our capacity to quickly remobilise and refocus the NHS to prepare for what, at that point, were reasonable worst-case scenario estimates coming from the scientific advisory group for emergencies, and from scientific and clinical colleagues. Competing priorities and resource pressures are a constant feature in health, as in any other part of Government, and we simply have to manage those as best we can.

Alex Cole-Hamilton: Thank you. I am glad that you mentioned the WHO checklist. I have it in front of me. It is called "A checklist for pandemic influenza risk and impact management: building capacity for pandemic response". It mentions "testing" 25 times, yet operation Silver Swan does not mention it once. If you were not using the WHO checklist thoroughly, what were you checking operation Silver Swan against? Do you now accept that the failure to consider mass testing in Silver Swan set us back considerably in handling the pandemic?

Jeane Freeman: I have the WHO checklist in front of me too, Mr Cole-Hamilton, and I have read

the entire document. I do not accept that there was a failure to consider mass testing. It was clear from the clinical and scientific advice and the four-nations plan—it was a four-nations approach—that the first phase of our response would be to attempt to contain the incidence and prevalence of Covid-19.

Contact tracing, test and trace—and, now, test and protect—have been key features of that response, with the expectation that, because of how the virus operates and how it is transmitted, we were likely to have to move to the delay phase, when steps are taken to suppress the incidence of the virus. At that point, its prevalence is such that contact tracing is no longer an appropriate response—it will not work; it is not possible to isolate clusters of the virus in the way that it could be done in the first phase.

The testing strategy must be flexible enough to operate where it is needed, which, at that point, was by ensuring, where possible, that key workers who were isolating because of a household member could be tested so that they could return to work if they did not have the virus. Surveillance testing was part of that.

Therefore, the testing strategy has adapted to two things: first, to the significant increase in our testing capacity from where we were in February this year and, secondly, to how the virus is behaving and what we are learning about the virus and the capacity to suppress it, which is where we are now. We need to suppress it further. Within that, we are introducing the opportunity to ease lockdown measures but, critically, the test and protect strategy needs to operate alongside that, which it is.

Professor Leitch might want to add to that. It is important to understand the application of the WHO guidance and checklist to the different economic, social and healthcare situations that are found in countries around the world. The WHO needs to operate in such a way that what it says is relevant to all, but each country needs to apply that to its own situation, which is what we have done.

Alex Cole-Hamilton: Thank you for that answer, cabinet secretary, but I come back to the checklist in front of me. It mentions “testing” 25 times—surveillance testing; test, track and trace; contact tracing—yet you suggest that the WHO writes the guidance as a catch-all for everybody and that it does not apply to some people. The fact that we did not discuss it at all in operation Silver Swan suggests that we did not have a testing strategy.

Every non-Government witness who has appeared before the committee in the Covid-19 inquiry has said that we were hopelessly underprepared for testing and that we should have been mobilising life sciences and university labs for mass testing from the very start, but that just did not happen. Do you think that it was a misstep of your Government not to consider testing in operation Silver Swan?

Jeane Freeman: I need to say a few things, and then I will bring in Professor Leitch. First, I did not say that the WHO’s approach means that you can take or leave some of what it says. I said that every country needs to take the WHO guidance and apply it to its own situation in terms of its economy, its society and—in this instance particularly—its healthcare system, and that is exactly what we did.

Secondly, it is incorrect to say that we did not have a testing strategy. If we had not had a testing strategy, we would not have been able to do contact tracing at the very start of the pandemic, in the containment phase. We did that, and I do not hesitate to mention it. It was a key feature of our response to the Nike conference, and I am sure that you have read the University of Glasgow’s important piece of research and report on the outcome of that as well as other work. We had a testing strategy. It was developed as the virus spread, as its prevalence increased and as our capacity for testing developed.

I also do not accept that we did not engage with university labs and others. That is how our testing capacity has increased. It has increased in our NHS labs and through our partnerships with the universities of Edinburgh, Glasgow, Dundee and Aberdeen. NHS testing capacity is at its current level on that basis, complemented by the testing capacity in the Lighthouse lab.

I will bring in Professor Leitch, who is much more knowledgeable than I am about the WHO and its guidance.

Professor Jason Leitch (Scottish Government): Thank you, cabinet secretary and Mr Cole-Hamilton. You have covered the fundamentals of why the exercise did what it did. I will add some context for the exercises, including with regard to the convener’s question. In total, across the whole world, MERS has infected 2,500 people. This virus has infected 8 million people. This is a global pandemic. We have never said those words before. This is on a different scale to anything that the world has faced in living memory. Therefore, of course those exercises inform our response. In fact, I have been very relieved that the national, regional and local resilience partnerships have been in place and that we have been able to speak to the police weekly and to the integration joint boards and so on.

The Silver Swan exercise was for influenza—a well-established disease that is known throughout

the world, in all 194 member states of the WHO, with well-established vaccination and testing programmes globally. However, the treatment programmes are still poor. Influenza does not have the mortality rate of MERS, which kills 35 per cent of infected victims. The Covid-19 virus kills about 1 to 2 per cent of affected individuals, tragically. The two are incomparable.

Of course, it is possible to compare levels of resilience in terms of your having enough agility to respond to whatever you face, but I maintain that it was impossible to predict that this global pandemic would happen at this point with this virus. Therefore, you must have as much as possible in place and then, in an agile way, respond to what you have.

We took the WHO's advice—of course we did—as did Syria, New Zealand and Somalia. We applied that advice to our health system, to our PPE stockpiles—which we had—and to our testing ability and the testing science that was available to us, and we worked immediately to adapt to the present virus and pandemic and got to the position that we are in today.

The Convener: Thank you. Please be brief, Alex.

Alex Cole-Hamilton: I appreciate your contribution, Professor Leitch. You said that operation Silver Swan was for influenza—normal common or garden influenza—sweeping the world. However, the WHO checklist states that Governments should plan not just for normal flu but for novel viruses as well. I cannot think why, in all the corridors of Government, nobody at that point thought, "Maybe we should expand this to something we haven't seen before—perhaps something that is more sticky, more virulent or busy—that kills more people." Why was that never factored into the planning around Silver Swan?

Professor Leitch: It was not because we are bad people, Mr Cole-Hamilton, that is for sure—

Alex Cole-Hamilton: I did not say you were bad—

The Convener: I call the cabinet secretary. I am sure that you will get another opportunity to speak.

Jeane Freeman: Thanks, convener. As Professor Leitch was about to say, in planning for an influenza pandemic—and the WHO checklist is for influenza pandemic preparedness planning—the point is precisely that you must have those core elements, which is why I read them out in my opening statement. The core elements are the foundation on which any pandemic planning must rest. The key is then to have the flexibility to adapt that to the particular virus or infection that you are confronting.

As Professor Leitch said, compared to influenza, which was previously considered to be the highest risk for a global pandemic, the scale of the Covid-19 pandemic is considerable. Those foundations of pandemic planning are contained in our resilience planning in Scotland—and in the rest of the UK—and they have allowed us to respond as quickly as we have and to adapt to what we face.

Undoubtedly, there are lessons for us to learn from that for our future pandemic and resilience planning, and I am happy to indicate what some of those lessons might be in due course. We will have lessons that we need to learn, as will our regional and local resilience partnerships. They will want to feed things into us so that, in our next iteration of pandemic planning, we will have learned from the current situation, which has to be one of the largest-scale pandemic exercises—and one that is real—that we have had to deal with.

09:30

Professor Leitch: I simply add that I would not describe flu as "common or garden". Flu kills 500,000 people a year globally, including many thousands in the United Kingdom. Preparing for standard winter flu is an enormous exercise across the UK every year, and preparing for a flu pandemic, which we anticipate would kill many more than 500,000 people globally, is also a worthwhile thing to do. Inside that, we can think about our resilience for other more novel attacks from bacteria or viruses, such as the one that we now face.

Brian Whittle (South Scotland) (Con): Good morning, cabinet secretary, and thank you for giving up your time. It is nice to see Professor Leitch and Mr Connaghan on the call.

My question follows on from those previous comments, because I want to look ahead to how we would potentially change our approach, given that the current pandemic was difficult to predict, as Professor Leitch said. In Professor Sir Ian Boyd's comments on the national security risk assessment and what might come down the line, he said that the NSRA does not consider "aggregate risk". I have a simple question to start with. Given that we live on a small island, is it realistic, possible or even desirable to depart from UK-wide planning for identified national risks?

Jeane Freeman: I do not think that we should be quite as binary as saying that that should be done by either the UK or the individual nations of the UK. Collectively, all four nations of the UK have attempted to recognise the areas that require a four-nations response, but within that we have recognised that each part of the UK may implement the response at a different pace or in a slightly different way. In the response, we are

attempting to manage and apply devolution, if you like. So far, we have done that reasonably successfully.

It was entirely appropriate for us to work towards and agree a four-nations plan in our response and to actively use the expertise and experience of SAGE, NERVTAG—the new and emerging respiratory virus threats advisory group—and the various groups that feed into those. It was also appropriate for us to establish our CMO's advisory body, which links directly with SAGE but allows the evidence to be applied to the particular situation in Scotland. Even in terms of geography and demography, there are differences in what we are responding to.

We have to keep on trying to manage both approaches. Although there is an overall risk that applies across the United Kingdom, there are differences in how that risk might evidence itself in different parts of the country. For example, there are differences in how the virus is playing out in different parts of England. We are learning about the impact on particular cohorts of our population—not simply those who are older, but those with particular underlying health conditions or characteristics. We are learning about that as we go.

It is worth making the point that the virus is a new one and that we are genuinely on a journey of learning that is led by all the scientific work that is going on. I have heard Professor Leitch say that the global scientific community has never worked as fast as it is doing right now to understand and anticipate what the virus might do and how it might perform. That is important for us, because although we are at the beginning of summer, we are looking ahead at what winter might bring us, such as seasonal respiratory illness, flu and other conditions, and at where we need to be with this virus before what comes at us in the normal course arrives.

Brian Whittle: Thank you for that answer, cabinet secretary, but I am really looking not so much at how you responded this time as at how we can learn from that and how we can move forward and plan for identified national risks. We mentioned operation Cygnus, which was a major planning exercise that identified the fragility of the supply chain. As the Royal College of Physicians has suggested, that fragility was not acted on. It goes on to say:

"it would have been helpful to have more focus on wider public health and the health and social care system as a whole, rather than concentrating on secondary care and the NHS".

With that in mind, looking at how it worked out this time, how could the Scottish Government in the future consider resilience in terms of an aggregated risk in relation to health and social care?

Jeane Freeman: It is important to say that operation Cygnus was about the position in England, not in Scotland. Operation Silver Swan was held the year previously, and the NHS in Scotland did not participate in operation Cygnus. It was not invited to participate, and neither were our local authorities.

Although the lessons from operation Cygnus are of interest and are important, they are not as directly applicable. I therefore do not accept that there was fragility in the supply chain for PPE in Scotland. It was sorely tested and it had to scale up the volume of its ordering and diversify the routes that it took to deliver on supply, not least because it extended the supply beyond the NHS significantly into primary care, community pharmacy and social care, and beyond that to unpaid carers, personal assistant and funeral directors and so on. There was huge demand on that national procurement service, but the very fact that we had one—that we had a stockpile, a distribution network and a body of suppliers—stood us in good stead.

There are, however, lessons to be learned, not the least of which is about the range of distribution routes that we fairly quickly put into place, which we would want to give serious thought to being able to retain for future planning. We have already learned lessons from our response that, to my mind, will be features of future resilience planning, and we would want to retain those. As Brian Whittle suggested, part of that will be a whole-system response, which is a health and social care response to an infectious disease pandemic.

The practicalities of the response have constituted a whole-system response. Health and social care partnerships, local authorities and other colleagues have been intimately involved in the planning and the implementation of our response.

Did we give sufficient consideration to the impact of the virus on primary and social care as opposed to secondary, hospital-based care? Arguably our initial response was led by the view that 80 per cent of the population would be infected and that 4 per cent of that number would require hospitalisation.

That was the worst-case scenario that we responded to, and it required a significant remobilisation and refocusing of the NHS, upscaling our ICU bed capacity and so on. We were aware of the importance of social care and of the vulnerability there, but we made some assumptions that, in practice, were arguably too strongly made in relation to the reality of how things panned out.

One of those assumptions was about the level of infection prevention and control measures in residential settings across adult social care, which should flow from the "National Infection Prevention and Control Manual". However, as we quickly appreciated, sufficient additional support was needed to ensure that those measures were in place.

Brian Whittle: As the cabinet secretary knows, I have certainly not been critical of the way in which things were initially instigated around the virus, but we have to learn lessons. I think that many people, especially those working in social care and the NHS, would be surprised to hear you say that you did not think that there was initially fragility in the supply chain for PPE. As I say, we have to learn our lessons.

My final question is about two of the major behavioural instructions that were employed: lockdown and physical distancing. Many of the submissions that we have received suggest that there was no discussion in previous planning exercises and scenarios for pandemic flu conditions that would require the imposition of lockdown or physical distancing. Shetland Islands Council said:

"Plans did not anticipate the scale of the consequences of lockdown."

Will lockdown, physical distancing and use of face masks become stock responses in any future pandemic, whether of flu or otherwise?

Jeane Freeman: I will make one point on PPE. I do not accept that there was fragility in the supply. There was a need to improve the distribution network, and that is the basis on which many of the initial glitches around delivery of PPE to where it needed to be delivered arose. Our response was to introduce four different supply routes. We never at any point ran out of PPE or any element of it. In fact, we were able to—and were happy to—supply both NHS England and NHS Wales as part of the mutual aid arrangements.

Would lockdown, face masks and physical distancing be part of any future response? It would depend on the nature of the infection that we were dealing with. The use of face masks and face coverings and physical distancing are driven by the scientific and clinical understanding of the virus and how it transmits. Other infectious diseases might transmit in a different way, so we would introduce other measures in order to break the chains of transmission.

In our toolbox of ways of responding, we now have experience of lockdown measures and of using distance, whatever that might be, as means of breaking transmission chains. We have use of face coverings and use of particular types of PPE in clinical settings. All that has been driven by the response to this particular virus and how it is transmitted. Other viruses or infections will be transmitted in different ways, so we might not always use those measures in the future; we might use other measures.

Sandra White (Glasgow Kelvin) (SNP): Good morning, cabinet secretary, Professor Leitch and Mr Connaghan. It is very nice to see you. My questions will be centred on local government and central Government. Professor Leitch mentioned partnership working, and in her opening comments the cabinet secretary mentioned pandemic planning, national and local interventions and flexibility.

09:45

My first question is about subsidiarity and various points of control. In submissions to the committee, Andrew Kerr from the City of Edinburgh Council said that

"incidents should be managed at the lowest level practicable under the principle of subsidiarity",

and North Ayrshire Council described successes in dealing with issues quickly according to planning that was put in place via community planning partnerships. It is supportive of those partnerships and their ability to deliver in local communities, but it has concerns about duplication, conflicting guidance from the Government and multiple reporting demands. What is your view on subsidiarity in relation to the response to Covid-19 in health and social care?

My second question concerns an issue that you have already touched on, cabinet secretary. How will you balance in the future the clear statutory responsibilities of local authorities and health boards with centralised control, given the experience of some local authorities? I mentioned two, but Shetland Islands Council also has concerns about various aspects of control.

Jeane Freeman: Subsidiarity is important, and I remind the committee that resilience planning and partnerships operate at national, regional and local levels for precisely that reason.

The Scottish Government's resilience operation directly involves the police and fire services and the health service, but it also involves the Society of Local Authority Chief Executives and Senior Managers, of which I think Andrew Kerr from the City of Edinburgh Council is the president or chair, and the Convention of Scottish Local Authorities. The president and the chief executive of COSLA attend the resilience meetings and are members of that operation. That is all about ensuring that we agree a collective national approach, much of which is then implemented at local level. The NHS is different in that it is the single organisation

across Scotland and there is clear national direction and delivery.

Local resilience partnerships have been responsible for local delivery and the capacity to respond quickly, as they have done, to everything that has been needed, from supporting the local distribution of PPE and ensuring that essential services were maintained to now providing accommodation for anyone coming into the country who is required to enter quarantine and does not have suitable accommodation. The approach to providing that capacity and the workaround shielding and support for the vulnerable will differ in each local authority because it has been driven and delivered at local authority level, but it was agreed that it was necessary in discussions at national level.

In much of the local primary, community and social care response, our health and social care partnerships, working with local authorities and the NHS locally, were actively engaged in ensuring that support packages were in place, and the additional funding that we have made available was channelled through local government or those HSCPs.

In due time, there will undoubtedly be a number of areas of feedback from the local, regional and national resilience partnerships about lessons to be learned and improvements to be made. I think, but I do not know, that those will be about communication channels and perhaps a need for greater clarity in the guidance, and I think that that would be fair.

At times, people have perhaps felt that there has been too much guidance and they have not been sure which guidance they are supposed to follow. That is partly a reflection of the speed with which the learning has been driven by the virus. A lot of clinical and practice guidance has changed much more frequently than we would expect or anticipate for this kind of pandemic planning. The nature of the virus and the speed with which we have learned about it have necessitated that, although I accept that it can be confusing and frustrating for people who are then charged with implementing that guidance.

Sandra White: I recollect mentioning guidance before and getting the reply that people were quite confused in that respect.

I am interested that you mentioned SOLACE and COSLA. I would assume that, for the sake of clarity, they would be involved in any guidance that is given to local authorities with regard to changes.

We have had correspondence from local authorities and we have heard that they feel that central Government has perhaps interfered—I will use that word—too much. Are there any particular areas where the Scottish Government has had to interject because local authorities have not delivered according to local needs, local knowledge and local infrastructure? Is there any particular area, apart from the guidance that you spoke about, where central Government has had to interject to address issues that were not being dealt with?

Jeane Freeman: I can speak only for my health and social care portfolio. Other cabinet secretaries might have different views in relation to local government and communities, although I am not aware that they do. Likewise, the Deputy First Minister, who leads the resilience response at the national level, might have a different view.

I would not describe the Scottish Government's role as being one of control. The Scottish Government has a clear responsibility and accountability for setting the strategic direction and the requirements, but we have to do that with those who are charged with the delivery. In some of this work, the delivery partners are local authorities, but they can also be health and social care partnerships or, in my case, individual health boards.

From my perspective, in my portfolio, there have not been areas where we have intervened. We have had discussions with individual local authorities, for example on the provision of social care packages when there was concern that pre-existing packages were being reduced or removed as part of a response to the pandemic. I do not believe that that should be happening, so there has been a conversation with the local authority partner about what is driving that and what it needs for that not to happen. We can then see whether we can provide that.

The additional resource was put in place partly in recognition of the fact that there would be an impact on staffing. For example, in social care, staff could be off work because they had the virus, because someone in their household had the virus or because they were in the shielding category. Staffing issues will impact on the social care workforce as well as on the NHS workforce. That was anticipated and planned for, and we issued the call for people to return to service partly so that we could deploy that additional resource and help to strengthen staff rotas where that was needed, both at local authority level and in the NHS.

From my perspective, there has not been a situation in which we have intervened. There have been conversations where what we are asking for has not been clear or where it has been evident that a local authority has been facing obstacles that we have needed to try to help it resolve. For example, I highlight the clarity that was brokered and provided through a conversation between me, COSLA and the relevant unions on what would

constitute clear guidance for social care staff on the correct PPE that they should be able to access and would be expected to use.

Sandra White: You mentioned resources. My understanding is that local authorities have been given an extra £155 million—it might not be in their bank accounts, but they have it. I met my local authority, Glasgow City Council, and it told me that the money was there. Is a proportion of that extra money intended to be used to support social care or community-based wellbeing services? Is that your responsibility or the responsibility of local authorities?

Jeane Freeman: We have given a commitment to provide more than £300 million, of which £155 million is consequentials. Additional money is going from the Scottish Government to local authorities, over and above the consequentials. In addition, I have committed an initial £50 million that will be directed entirely towards the social care sector.

I imagine that the £300 million in direct additional support for local government will be used primarily for Aileen Campbell's portfolio to support communities and local authorities in providing additional support in their response to the pandemic. On top of that, I have made sure that there is additional money for social care. There has been an initial £50 million to support social care, and if more is needed, there is an opportunity for us to consider providing it.

Sandra White: You have possibly answered my final question, cabinet secretary, so you could just say yes or no. Will the learning from local partnerships on health and social care, which we have talked about, be taken on board or considered? I think that you answered that when you talked about sharing learning for future planning. I do not know whether you want to elaborate on that or just say yes or no.

Jeane Freeman: Yes—it will be taken on board. The Scottish resilience partnership, which is led by the Deputy First Minister, will undoubtedly initiate that work.

As I said at the outset of the meeting, some work has already begun to ensure that lessons are learned as we go, so that we capture everything. Although that work has been happening for only a few months, the pace of the activity has been considerable. We need to capture lessons as we go and ensure that we do not lose any of the learning.

The Scottish resilience partnership will undoubtedly lead a major exercise that will involve input from local and regional resilience partnerships. In addition, I am sure that the DFM will in due course lead a cross-governmental exercise so that all the Government partners can feed in our individual lessons as part of our intergovernmental working both within the Scottish Government and with the other nations in the UK.

David Torrance (Kirkcaldy) (SNP): My questions are on communications and technology. What barriers are you aware of that have hampered good communications with key stakeholders in primary care, community pharmacies, care providers, and health and social care partnerships? What measures have been considered to clarify and simplify key lines of communication for the future?

Jeane Freeman: A number of objectives that existed before the pandemic but had not been completely achieved have been achieved and secured during our response to the pandemic, in a very short space of time. That has been partly to do with how we have delivered healthcare. One such area is the—I think—significant improvement in direct communications. That covers everything from my now fortnightly, although it used to be weekly, call with the British Medical Association and the Royal College of Nursing to our communications with Scottish Care and the discussions that officials have weekly, if not daily, with key stakeholders in community pharmacy and primary care.

10:00

John Connaghan, who has just joined us, might want to say something about the constant communication with our NHS boards about issues that are being addressed, problems that are to be resolved and planning that is under way. I add that officials have regular calls with chief officers of health and social care partnerships and I have regular calls with my counterpart in the Convention of Scottish Local Authorities, Councillor Stuart Currie.

Communication has probably increased significantly over the course of the pandemic, and it continues. That might be partly because we cannot meet, so we talk more frequently.

No issues to do with communication have been raised with me. There might have been times when the pace of what we have had to do to respond has foreshortened the normal process of consultation before decisions are made and steps are implemented. However, most stakeholders completely understand that. When it comes to care homes, we now have the rapid action group, which brings together all the key stakeholders so that there is much more consultative work—albeit over a shorter timeframe—before decisions are taken about additional steps or support for the care home sector.

The framework for mobilisation recovery group—under the remobilise, recover and

redesign framework for our health service—will meet before the end of the month. It comprises a wide range of stakeholders from the clinical community—the royal colleges, our boards and our health and social care partnerships—and from social care, with COSLA, the Society of Local Authority Chief Executives and Senior Managers and other key stakeholders all being involved. I will chair the group, which will consider how we remobilise and redesign our NHS as we move, I hope, out of the pandemic.

David Torrance: What work is under way to create information technology platforms for emergency purposes that are shared between all community planning partners, especially health and social care partnerships?

Jeane Freeman: We have Resilience Direct, which is a well established and secure IT platform. It is maintained by the Cabinet Office and it enables UK-wide resilience partners and practitioners to work together.

In the context of Covid, we are building on the excellent data and expertise that we have in Scotland. The Scottish Covid-19 data and intelligence network is leading on a range of activities to provide us with real-time data and intelligence to inform an effective pandemic response at all the levels that we have been discussing. Clearly, that will serve us well for the future, too.

We are making the data accessible to planning partners and other organisations. It is used extensively, for example, in the new management information system for the test and protect strategy. Statistics have already been produced from that.

At the end of May, we launched the new Covid-19 research data service, which provides secure access to data for planning partners, academia and others, so that they can get answers to key analysis and research questions about the spread of, risks from and effects of Covid-19. That helps with planning and the research helps academia in its work, which feeds back to us and in turn informs our planning response.

David Torrance: You mentioned care homes. Will you say more about progress on a digital strategy for care homes?

Jeane Freeman: Covid-19 has shone fresh light on potential uses of digital technology in care homes. That includes improving data flows and encouraging homes to engage with healthcare in more effective ways, rather than healthcare necessarily always having a physical presence.

Work is under way in both those areas: the focus is on creating a web platform for the recently introduced safety huddle tool that we have issued to care homes, and on developing new capacities for virtual visits. That will be of assistance to residents in care homes soon and, again, will have longer-term functionality for care homes.

We have also provided NHS emails to care homes so that there can be secure communication between care homes, and between care homes and GP surgeries and other services that are involved in residential care. That allows patient-identifiable information to be transferred, which speeds up access to clinical care. It also allows speedy communication between the NHS and care homes about clinical support that a care home might need, and about NHS discharge procedures. A lot of work is under way.

A cross-sector group that includes the Scottish Government, the Convention of Scottish Local Authorities and local authorities, is looking at introducing an initial digital strategy by July. The care home rapid action group inputs to and engages with that process, to see where there is more that we can do. NHS “Near me” digital technology is being used to provide consultations, not only for primary care, but for wider services including family nurse practitioners. That is clearly of direct relevance to, and is being tried in, residential settings. There is also the vCreate video message service and other things that I am happy to set out following the meeting, if that will be helpful.

The Convener: That would be helpful, cabinet secretary.

David Stewart (Highlands and Islands) (Lab): I pass on my best wishes to Professor Leitch, who is becoming a well-kent face in the Scottish media, as is Mr Connaghan.

The Royal College of General Practitioners concluded in its evidence to the committee that

“The ... pandemic has shone a light on persistent health inequalities that continue to exist in Scotland.”

All the witnesses will know this, but people who live in our most deprived areas are more than twice as likely to die with Covid-19 than those in the least deprived communities. That is a disgrace. What action is the Scottish Government going to take to reverse health inequalities?

Jeane Freeman: Mr Stewart is absolutely right about the light that has been shone on the people who are most severely impacted by Covid-19. Evidence is emerging about the longer-term impacts, for those who have had the disease, on their respiratory, cardiovascular and renal functions. I will ask Professor Leitch to expand on that, because he is more knowledgeable than I am, but there is a clear indication that some underlying health conditions might make an individual more susceptible to a serious response

to the infection and make it more likely that the infection will cause serious ill health in those individuals than that it will do so in others who do not have those underlying health conditions. Some of those conditions, of course, relate to circumstances of poverty and deprivation. We are very clear on that.

I have had conversations with the chief medical officer and have tasked senior officials—not least, Carol Tannahill, who works, as I am sure Mr Stewart knows, in the Glasgow Centre for Population Health, and whose experience and expertise we benefit considerably from—with early work on what more we need to do to tackle population health, especially in relation to health inequality.

There is now a clear and pressing demand for us to find more effective ways of reducing health inequalities and of reaching groups of people with important but practical ways to improve their health. So far, we have not successfully done that in 20 years of devolution. Therefore, there is much more for us to do, and we have already tasked the initiation of that work. Perhaps Professor Leitch can add to that.

Professor Leitch: Mr Stewart is absolutely correct to suggest that almost every disease imaginable has a gradient that is related to health inequality. Covid-19 is no different. Unfortunately, the global pandemic reveals such health inequalities in every country that it touches, whether it is South Korea, Wales or Scotland. It is a sad fact of life that the poor get sicker; therefore, the poor get sicker with this disease.

Covid-19 affects people with vascular diseases, such as diabetes and heart disease, and it affects obese people and the elderly. Pretty much everything in those comorbidities has a higher prevalence in poorer communities. Therefore, the response in the medium to long term must include consideration not only of the national health service, but of drugs and alcohol services, education, housing, community services and all the other areas that apply, as the committee knows perfectly well, in dealing with health inequalities.

Covid-19 is shining a new light on the inequalities. The cabinet secretary is absolutely right that there is nothing good about a pandemic: it is misery. However, if one good thing can come out of it, it is the renewed focus in Scotland on the health inequalities that this infectious disease has brought out into the light again, and the solutions to them.

David Stewart: Thank you.

I and colleagues in the relevant cross-party group have a great interest in diabetes. I am very concerned about obesity, and I realise that there are links between it and Covid-19. As Professor Leitch and the cabinet secretary will be well aware, approximately 80 per cent of type 2 diabetes cases are related to obesity. We need a cross-cutting approach in the Scottish Government, because that is a disease that really concerns me when it comes to Scottish health inequalities. Do the witnesses agree with that we need to consider cross-cutting policies in order to really tackle the appalling health inequalities in Scotland today?

Jeane Freeman: I absolutely agree. We need to consider more forensically what a cross-cutting and cross-Government approach should look like. I do not have an easy answer for Mr Stewart, but the health portfolio has a critical contribution to make to that. However, as Professor Leitch has said, so too do our capacity to grow the economy, effective engagement with communities, how we provide services with our partners in local government and, importantly, listening to communities themselves.

People do not wilfully decide to be unhealthy or overweight and inactive. We need to hear from them about what prevents them from living a healthier life, and we need to know why what we say is simply not being heard. That is one of the key areas of work for our citizens jury—which was led by our former CMO, and is undoubtedly now led by now our current CMO—and it was included in other recent participatory engagement by other parts of Government with communities and local government, on, as I well recall, the social security system.

We need to employ such measures in order that we hear from people themselves about what they need from us, so that we can help them with their health, activity and so on. We can use their responses to inform the practical steps that we will take.

10:15

I would like to mention another area in passing—by which I do not mean to suggest that it is not important. There is an emerging—at this stage, it is very much just emerging—understanding of the vulnerability to the virus of the black, Asian and minority ethnic community. The emerging data, research and understanding are informing some immediate steps, such as interim guidance through our health boards about particular risk-assessment approaches with staff from the BAME community. However, there is more work to do on that, which will inform a wider understanding of the impact of viruses and infectious diseases on different cohorts of our population.

David Stewart: There might well be future pandemics or, of course, regional health emergencies, such as the 2001 foot and mouth disease crisis. We can see in the crystal ball that the poor would get a raw deal in those. How can we turn health inequalities on their head and place disadvantaged people at the top of the list?

Jeane Freeman: That is a very important question, and I am much taken by how Mr Stewart has put it. It is entirely fair to demand of this, or any, Government that, as it plans its health emergency response, its early thoughts go straight to those who are most disadvantaged in its society, and that it works out how an infectious disease or virus—whatever it might be—will most likely impact on them. There might be more than one group of such people, depending on what the science and understanding of the virus and infection tell us. What protective and mitigating steps should we take for them?

We required the people whom we assessed as being at highest clinical risk of serious symptoms and death from the virus—those in a shielding category, whom we identified through the clinical conditions that apply with Covid—to take protective steps, and we put in place support for them to do so. There is an argument that one of the strongest lessons that we have learned from the experience is that that way of thinking should be factored into our future planning.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I have followed the evidence session with interest. There has been a concern in the evidence that the committee has received that, in covering the response to the pandemic, the media have understandably focused on planning and resilience in traditional health and social care settings—hospitals and care homes.

Some stakeholders, such as Community Pharmacy Scotland, suggested that pharmacies could perhaps have been more involved with messaging at the start of the pandemic response—to stop people panicking about repeat prescriptions and to make it clear that pharmacists were key workers in the response—and that there could have been consistency in the way in which health boards dealt with additional demands in the community and the redeployment of staff there. I wanted to put that on the record on behalf of Community Pharmacy Scotland, with regard to the outset of the pandemic.

We also got evidence from the Royal College of Pathologists that it could have been more involved in working out and establishing the best use of laboratory basic capacity in responding to the pandemic. I note that it still has a degree of concern about how the diagnostic backlog of cases will be attended to, and I understand the pressures in relation to that.

The reason why I mention that is that, to a greater or lesser extent, witnesses are keen to ensure that they are part of the discussions with Government and the health service about resilience planning in relation to pandemics. What reassurance can you give that a more holistic approach to planning will be taken, as we see out—I hope as soon as possible—the issues to do with this pandemic, while preparing for the pandemic that, unfortunately, will inevitably arise at some point in future?

Jeane Freeman: You made a number of points. I will do my best to be as brief as I can be and, if I may, I will bring in John Connaghan, as chief exec of the NHS, on the important point about the diagnostic backlog to get a response to that on the record.

Community Pharmacy Scotland was one of the first groups that I met to talk about its role and response in the context of primary care. Although, as you know, we paused the introduction of pharmacy first, which will happen shortly, we significantly increased the role of community pharmacy in minor ailments and the provision of primary care—it had always been in the right place to take on such work, and we extended its role. We also removed some technical issues, for example to do with prescriptions, that were preventing the sector from doing as much as it could.

Community Pharmacy Scotland, the Royal College of Pathologists and others will, I am sure, have an important input into how we build the lessons that we learn from this pandemic into our planning. Resilience planning sits within a clear legal framework, which sets out the level 1 and level 2 responders, but that does not preclude our hearing from others, and I am happy to ensure that we make the effort to widen the net so that we hear from all the royal colleges. We have been actively engaged with a number of the royal colleges in the context of the pandemic and we remain engaged with them in the context of our planning for the NHS and the remobilisation work. I am happy to give that assurance, notwithstanding the fact that the resilience work is set within a clear legal framework.

I will ask Mr Connaghan briefly to update the committee on the approach that we are taking to what we are well aware is a diagnostic backlog, bearing in mind that the nature of remobilising the NHS while we are still in a pandemic is such that what we do must be done safely and more slowly than it otherwise would be.

John Connaghan: Part of our response in this emergency phase of the pandemic is to keep a very close look—on a daily and weekly basis—at our use of the capacity of the NHS. We are doing that primarily to ensure that we have enough free

capacity to deal with Covid but also because that work tells us about the backlog of routine diagnostic out-patient and in-patient services that is gradually building up.

In the first phase of work to stand up services again, which is covered by the remobilise, recover and redesign framework, we have asked boards to respond on a basis of re-establishing urgent services, which includes diagnostics, up to the end of July. That is the first phase of re-establishing services in the NHS in Scotland.

The next phase, which will be from the end of July right through to the end of the financial year in March 2021, will be much more important in tackling the backlog. It needs to cover not only health board planning but what we can do additionally. Work is under way to consider whether we can source and then deploy quickly some mobile units to bring services to patients. They would cover things such as computed tomography and magnetic resonance imaging scanning. That is actively under consideration, and we may well start it in the latter half of the first phase, between now and the end of July.

Looking ahead, I note that Scotland is relatively fortunate in that, a few years ago, it embarked on a strategy to build and create additional elective units, all of which would have diagnostic capacity. The plan was that they would be brought on stream gradually out to 2035, but we probably need to re-examine how quickly we can scale them up and deploy them.

I would like to put in your mind that there are two responses to the issue—a short-term one and a longer-term, strategically driven one.

Bob Doris: You have provided some reassurances around Community Pharmacy Scotland. To be fair to it, I note that it was talking about the very early stages of the pandemic response, but it is good that you have put that on the record.

Cabinet secretary, time is against us this morning, so I will ask just one final question. In its evidence to the committee, the Royal College of Physicians made a positive suggestion that I would like to put on the record and get your response to. Some of this might already be happening, but it suggested in relation to planning and resilience that sleeping contracts should be put in place for items that are required to respond to a pandemic, including PPE, pharmaceuticals and resources such as laboratory space and staff. That would be a proactive approach to ensure that, should a terrible pandemic happen again, the level of preparedness would be far in advance of where it was this time. Sleeping contracts could be a very helpful idea to take forward. What is your response to that?

Jeane Freeman: I am certainly happy that we consider that as we look at what more we need to do in terms of future pandemic planning.

I make the additional point that, as you will know, thanks to my colleague Mr McKee, as our Minister for Trade, Investment and Innovation, we have now successfully established a domestic production and supply chain for important elements of PPE. It covers masks and aprons, and I believe that gowns are coming on stream, too. I hope that that will increase the volume of supply in normal course, but it will also be an important future mitigation if we have another global pandemic, because it means that we are less reliant on the global marketplace, with all the pressures that it has been and will continue to be under in the circumstances. Mr McKee is now turning his attention to other areas of supply.

I am happy to give an assurance that we will consider that proposition as well as all the other areas that we need to learn from as we look at our future planning.

Miles Briggs (Lothian) (Con): Good morning, cabinet secretary and panel. My questions follow on from what Bob Doris said about the return of NHS services. We know that, last year, almost 83,000 of our fellow Scots did not receive treatment within the time in the treatment time guarantee. In relation to the response to Covid, what commitment can patients expect from ministers, given the pressures on the NHS over the past four months?

Jeane Freeman: I am sure that Mr Briggs has read the framework carefully. There is a recovery group with all the key stakeholders, which I will chair. I will be writing to the convener with more details on that, and it will meet before the end of this month.

10:30

The framework document is clear that we cannot flick a switch and turn the NHS back on as it was at, for example, November or December of last year. That is simply not possible, for a number of reasons, the first of which is that we are still in the middle of a pandemic. We still have Covid cases and a virus to suppress and control, and we need to retain capacity to ensure that we can cope with a second wave, if one comes. All of that is vital. We also have a health service in which a significant proportion of the workforce are both physically and emotionally exhausted from the efforts that they have made to address the immediate pandemic response that has gone on for very many weeks. The RCN, BMA, Unison and many others have made that point. We therefore need to create the space for that group of staff to recover. That will mean, for example, that the

group of returners whom we secured to respond to the pandemic might have to be held on to for longer in order to allow recovery time for the staff.

All that, along with the planning that Mr Connaghan has described—initially to the end of July, but more strategically and importantly through from then to the end of the parliamentary session—will have factored into it what exactly we can realistically, openly and with the best attention to clinical priorities say to patients about what they can expect for their treatment and the time before they are treated for their particular conditions. We also have to ensure that we retain some of the innovative, safe and clinically productive ways of delivering healthcare that we have seen in the NHS's response to the pandemic so far.

Miles Briggs: Yesterday, we heard concerns expressed by orthopaedic specialists about the need for a significant increase in capacity and the fact that, if that is not put in place, there will be severe increases in waiting times. For example, orthopaedic specialist John Dearing said that he was worried that waiting times could increase from almost one year to three years. What is the cabinet secretary's response to that? How will capacity be put in place to ensure that people do not face that sort of waiting time?

Jeane Freeman: I will make two important points and then I will bring in Mr Connaghan. First, I make no apology for repeating myself by saying that we are still in the middle of a pandemic. It has not gone away; it is still there. Our NHS is therefore still responding to that pandemic, as am I and all my senior officials, not least the chief executives of our NHS divisions. Secondly, alongside that, we are making every effort, in a way that is clinically safe and allows the health service to retain capacity to respond to the pandemic, to work through the best ways by which we can restart NHS services across the primary, secondary and acute sectors, while retaining the important, innovative and effective steps in the delivery of healthcare that have appeared or been upscaled in response to the pandemic.

The answer to Mr Briggs's specific question is that it would be irresponsible of me at this point to pre-empt that work by our boards and Mr Connaghan's due consideration. That is the point of the planning initially to the end of July and then, more importantly, from July through to next March. As soon as we are able to respond more directly to those legitimate concerns and questions from patients as well as from senior clinicians and others, we will do that. However, we need to work through that process at the same time as we respond to the pandemic.

Mr Connaghan has given a great deal of thought to all that and is leading that work with the considerable experience and expertise that he has gained over many years. He might want to add a few points to what I have just said.

John Connaghan: I will make this relatively short, given the time, Mr Briggs. It might be useful if I send you a copy of the note that I issued to chief executives and chief officers, COSLA and the chief executives of local authorities, which is about the next phase of the NHS response in terms of remobilisation. That six-page note lays out the detail that we expect to be taken forward in re-establishing services—including orthopaedics, but also many others—between now and the end of July. That might give answers to some of your questions.

I will add a couple of other things about what patients should expect. They should expect a slightly different engagement with the NHS in the future through things such as the near me service, which replaces face-to-face consultations with digital consultations. We are finding that patients and clinicians are readily engaging with that, not just in the secondary care sector but in primary care. Some tens of thousands of patients have already been seen in a safer and faster way for initial assessment, including in orthopaedics.

The other thing that we should expect in the near future as part of the next phase of our roll-out of re-established NHS services is the creation of additional capacity where possible. For example, the Golden Jubilee hospital is already laying plans to expand its capacity significantly in the next phase. We expect to see a lot more detail on that when it responds on the period to the end of 2020-21.

Lastly, I go back into the territory of assessing risk. We do not do that in isolation but need to consider the balance of risks over the next six to nine months in terms of maintaining a Covid-19 response in the system while dealing with the backlog and also, as the cabinet secretary said, considering the workforce and, importantly, the impact of the coming winter of 2020-21. We all hope for a mild winter, but the balance of all those risks, which is exceptionally complex to plan for, needs to be in our plans for the next six to nine months.

The Convener: Thank you, Mr Connaghan. We look forward to receiving those notes.

Miles Briggs: That is very helpful. My final question is about stalled cancer-screening services. When are we likely to see those starting again, especially bowel cancer screening? How much of the lab capacity that is used for screening has not been utilised during this period?

Jeane Freeman: Mr Briggs can expect to see the screening programmes starting up very soon. Some of that will be covered in what the First Minister says tomorrow as part of the normal

review period, but—I think that I have said this in the chamber, and the First Minister has also made this point—we are very conscious that cancer-screening services are a really important priority area for us to recommence.

We need to be able to do that in a safe way, of course. The main challenge is with breast screening, but colleagues are working on how that can be done safely. Also, members will recall that we paused the programme so that we did not lose people. Part of the work that is under way is looking at how we can screen the individuals who should have been screened during the recent period while at the same time ensuring that we do not put in a delay for the people who would be coming up for screening now. We will have to run a bit of a parallel process, as best we can.

I do not have information on lab capacity in front of me, but I will be happy to look it out and send it to Mr Briggs and the convener.

George Adam (Paisley) (SNP): Good morning, cabinet secretary. You said that we are looking at what helps people to live healthier lifestyles. I have a question about healthy lifestyles and behaviours, and the balancing of lifestyles. There have been reports in the press and elsewhere about people drinking more alcohol and eating more during lockdown, mainly because eating three meals a day breaks the day up for people. There are other stories of people using this opportunity to go out and get fit—the born-again cyclists, such as the men of various ages going about Paisley in Lycra.

It is possible for you to get the data to see what is actually happening? If so, is there a way in which we can change people's behaviour when we move out of lockdown, or encourage people who have changed their lifestyle in a positive way to continue to do so?

Jeane Freeman: As I think you have probably seen, local authorities have taken steps to encourage people to keep cycling and walking. Part of our guidance to folks who have to travel to work says that they should cycle and walk as much as they possibly can in this period.

We are also working with Public Health Scotland and others, including the mental health advisory group, the drug deaths task force and the physical activity development group, on capturing the impact of Covid-19 and the response of the population against a range of health outcomes, including those relating to mental health, physical activity, diet, alcohol intake, use of drugs and tobacco, and weight. In the light of the pandemic, Public Health Scotland has developed a public health surveillance system for problem drug use, and other work is under way.

As a Government, we commission weekly surveys that provide some limited evidence on health behaviours and outcomes. We have recently commissioned Ipsos MORI to undertake a survey on health and wellbeing during lockdown. From the survey responses, we will try to understand where there have been positive changes and what we might do to encourage people to hold on to them. We will also try to understand where there have been negative changes in behaviour in terms of people's health or mental wellbeing and what we might do in response.

We commissioned a mental health tracker study of 2,500 adults in Scotland, which was launched on 28 May. The study will track the impact of Covid-19 on various aspects of participants' mental health for a year. The baseline survey is currently in the field and the results are expected in July, and we will then carry the study forward over the coming year.

In addition, the chief scientist office has funded around 55 projects that relate to Covid. Several of them are about understanding the longer-term health impacts of, for example, social distancing and other behavioural interventions that we have asked the population to observe to prevent the spread of Covid.

All that work is under way, and some of it will have immediate and direct relevance to how, as a Government, we respond in the months ahead.

George Adam: I am glad that you brought up mental health. My first question was about physical health, but we know that, in my constituency and in many others, many people had mental health issues before lockdown, some of whom have had to shield during it—I am thinking of one constituent in particular in that regard. There will also be mental health issues for people who, during lockdown, have had other challenges to deal with.

Will you give more detail on what you are considering doing when we come out of lockdown for those who have been shielding and who had mental health issues beforehand, and for those who have developed mental health issues during lockdown?

10:45

Jeane Freeman: A number of additional mental health supports have been introduced during the pandemic. One of those, the Clear Your Head campaign, will continue for some time, helping all of us to look after our own mental health and wellbeing. Some support services have been delivered in a different way. The NHS 24 mental health hub, Breathing Space and the distress brief intervention programme have all remained available throughout the pandemic. Our NHS mental health services have also remained open.

Although in many instances they have delivered in a different way, according to the information that we have so far received, patients and others who have used them have responded to them very well.

Members will know that, this afternoon, my colleague Clare Haughey will make a statement to Parliament that will touch on what has been done so far and where she wants to lead that work in the months ahead.

I also want to mention the mental health and wellbeing of our health and social care staff. A lot of support has been introduced, from very practical steps such as providing space to get a breather, sit and have a quiet five or 10 minutes in the middle of a shift and make a cup of tea, through to counselling and coaching services, provided by PRoMIS and based on trauma counselling, for individuals who have been in some of the most traumatic of situations as they deliver health and social care. We intend to continue all of that. Indeed, when the ministerial group that is looking at wellbeing and culture in our NHS meets this week, it will consider what we should retain, and it is important that we retain all of that as we come through the pandemic.

My final point is about the mental health needs of those who have been hospitalised as a consequence of Covid, including those who have been in intensive care on ventilation and have now been discharged. The rehabilitation process is long, and a significant part of it will involve mental health. We will be learning from our trauma network. A very important point is that the network has built in the psychological support that people who have experienced physical trauma in a major accident need, because support for physical healing and psychological support are both needed. That approach will be very helpful to us as we see what more we can do for the rehabilitation and support of those who have suffered from Covid-19 so seriously that they required hospitalisation and ICU intervention.

The Convener: That concludes the evidence session. I thank you, cabinet secretary, and your officials for taking part in the meeting, and we look forward to hearing from you and your colleagues with the documents that you mentioned.

Subordinate Legislation

Food Information and Addition of Vitamins, Minerals and Other Substances (Scotland) Amendment Regulations 2020 (SSI 2020/156)

10:48

The Convener: The second agenda item is consideration of one negative instrument. Do any colleagues have comments on the instrument? As there are no comments, does the committee agree to make no recommendation? That is agreed. Thank you.

That concludes the public part of the meeting. The next meeting of the committee will be at 9 o’clock on Tuesday. The agenda will be notified in the *Business Bulletin* and on the committee’s social media.

10:48

Meeting continued in private until 11:26.

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