OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 2 March 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 2 March 2023

CONTENTS

COVID-19 RECOVERY COMMITTEE
5th Meeting 2023, 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:

Dr Melissa Heightman (NHS England)
Claire Jones (Betsi Cadwaladr University Health Board)
Stuart McMillan (Greenock and Inverclyde) (SNP) (Committee Substitute)
Dr David Strain (NHS Long COVID Taskforce)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 2 March 2023

[The Convener opened the meeting at 09:41]

Long Covid Inquiry

The Convener (Siobhian Brown): Good morning and welcome to the fifth meeting of the COVID-19 Recovery Committee in 2023. We have apologies from Jim Fairlie, so I welcome Stuart McMillan as a substitute and invite him to declare any relevant interests.

Stuart McMillan (Greenock and Inverclyde) (SNP): I have no relevant interests to declare.

The Convener: We are continuing our inquiry into long Covid. I welcome Claire Jones, advanced clinical practitioner and long Covid therapy lead, Betsi Cadwaladr University Health Board, who is joining us remotely from Wales. I hope my pronunciation is correct. I also welcome Dr Melissa Heightman, who is clinical lead in the post-Covid service at University College London Hospitals and the north central London respiratory network. Dr Heightman is also a national specialty adviser for the long Covid programme at NHS England. Dr David Strain, who is a senior clinical lecturer at the University of Exeter medical school, is the lead on long Covid at the British Medical Association and a member of the NHS long Covid task force and joins us online.

I thank all the witnesses for giving us their time. We estimate that the meeting will run until approximately 10.40 and that each committee member will have approximately 10 minutes for questions. Witnesses who are attending remotely and would like to respond to any issue that is being discussed should put an R in the chat box so that we can bring them in. I am keen to give everyone an opportunity to speak and apologise in advance for having to interrupt members or witnesses in the interests of brevity if time runs away from us.

I invite all the witnesses to briefly introduce themselves.

Dr David Strain (NHS Long COVID Taskforce): You have already heard an introduction. I have been working on long Covid through the British Medical Association and clinically as Covid lead in my local long Covid service. I also collaborate with Mel Heightman on the STIMULATE-ICP trial of the best management of long Covid.

Claire Jones (Betsi Cadwaladr University Health Board): I am an advanced clinical practitioner and I lead the long Covid service at Betsi Cadwaladr University Health Board. Your pronunciation was absolutely fine. I set that service up around 18 months ago and have been working there since. Thank you for inviting me to come today.

Dr Melissa Heightman (NHS England): I am a general and respiratory physician. I have been leading the long Covid service at UCLH since May 2020 and we have seen about 4,000 patients. Since September 2021, I have been working with the national long Covid programme at NHS England as a national specialty adviser.

The Convener: I will begin the questions. The committee is very keen to see what work is being done on long Covid in the rest of the UK and what support has been put in place. Dr Heightman, how are long Covid services organised in England?

Dr Heightman: Long Covid services were commissioned at the end of 2020 and it was envisaged that there would be at least one service for each integrated care system. Currently, we have 90 such services in England. They have expanded from the assessment clinic that was initially envisaged to what is now a holistic assessment and treatment pathway, and they are designed to bring in the whole range of clinicians required to manage this multisystem condition, from doctors with different specialty experience to a wide range of therapists including psychology support. Importantly, primary care is involved, too. In short, the services have evolved into integrated networks within each integrated care system and are trying to drive proactive treatment of long Covid as a multisystem condition.

09:45

The Convener: Are those who present with this form of Covid referred initially by their local general practitioner?

Dr Heightman: Yes. Referral is via primary care. First of all, individuals have to understand that they might have a long Covid illness, and then they have a conversation with their GP and discuss whether they need to be referred on to the pathway or whether they can be managed by the GP. Referral is always through the GP or via another hospital specialist. Moreover, patients admitted with acute severe Covid have been proactively followed up after discharge.

The Convener: Is that approach consistent in each county in England?

Dr Heightman: The commissioning guidance sets the framework for what we are all trying to work towards, so the goal is consistency.

However, it has definitely been difficult to implement these complicated services with the constraints that the NHS is under at the moment and the workforce shortages, and I would say that the success of implementation will vary around the country. That said, we have seen steady improvement, with a reduction in waiting times, and, according to the friends and family test data, patient experience of accessing the services has been very positive.

The Convener: Thank you very much. That has been really helpful. Claire, can you tell us about the same issues in Wales?

Claire Jones: Yes. We have the all-Wales community pathway for long Covid, which was drawn up to complement the clinical guidance from the National Institute for Health and Care Excellence. It has been used to inform local pathways and ensure a consistent approach across Wales, but it also recognises that the services might be organised differently according to local needs and circumstances, so there is some variation.

The pathways ensure that patients can get personalised assessment and treatment for their needs and that care is provided as close to home as possible. As a result, we have more of a community model in Wales, with the aim of treating the symptoms that can be treated, promoting and supporting self-management and value-based care that can be accessed in the community and agreeing with the individual care that is tailored to their specific needs.

The seven health boards in Wales have all developed multidisciplinary recovery services that GPs and health professionals are able to refer into once screening for more serious symptoms has taken place, but what is unique about our service in north Wales is that patients can self-refer. That approach came about as a direct result of our collaboration with people with lived experience of long Covid and their desire for ease of access; it has been a huge success, despite the fact that there were some concerns and worries before we launched it, with some people saying, “It’s not a good idea.”

In fact, the approach has worked really well. We have not had any issues with it; actually, we have seen quite a high number of referrals for our population area. We are not seeing any more inappropriate referrals than we would with healthcare professional-only referrals, and we have a triage process to ensure safety and adequate screening, with, for example, urgent investigations taking place at the point of referral.

As I have said, there is definitely variation in Wales to meet local need and to take into account the different areas, both urban and rural, that we have and the organisation of pre-existing services. However, we regularly link in with other health boards in Wales as part of an all-Wales team; we are aware of variation, for the reasons that have been mentioned, but we are all continuing to work within the community pathway. Delivery methods might vary slightly, with some areas offering virtual consultations and sessions and others offering more of a hybrid approach of face-to-face and virtual sessions.

As for multidisciplinary teams, their composition might vary slightly due to recruitment challenges and service design.

The Convener: Thank you—that is helpful. I will bring in David Strain, but first I have a question for Dr Heightman. With referrals in England, do doctors diagnose someone with long Covid and refer them with an official diagnosis on their medical record, or is there self-referral for long Covid as well?

Dr Heightman: Someone can have suspected long Covid—the GP does not have to be able to confirm the diagnosis 100 per cent. That is often the reason for referral, as confirming a diagnosis of long Covid can be difficult in some cases.

A decision was taken against self-referral simply because of the uncertain medical risk within the patient group. People with long Covid present with breathlessness, fatigue and chest pain, for which there could be other medical causes. One in 20 people whom we see in my clinic do not have long Covid as an explanation for their symptoms, and we have picked up some other very serious conditions that are causing those symptoms.

The issue is how to manage the medical risk with self-referral. There are ways to do that, so long as people have the right medical support—I am not saying that self-referral is a bad idea—but that was the reason why it was not chosen initially. Long Covid services in England started very early, at a time when there was a lot of risk in the system.

Dr Strain: Like Mel Heightman, we have referral through GPs, and we, too, have picked up a lot of other diagnoses coming through. The worst that we had was a case of lung cancer that had been missed in someone who came through the long Covid service. That is why an initial primary care assessment is absolutely central, so that those core investigations are done.

The geography of Devon, where I work, is very different from that of central London. We have now moved away from a specific long Covid service per se towards more of a long Covid assessment and triage-based service. We currently have a hub-and-spoke model. Referrals come in and they are all assessed by a multidisciplinary team, and they are then referred out to an appropriate team locally, depending on what their needs are. For example, if people's key needs are based around breathlessness, they will be referred to the respiratory rehabilitation team wherever their closest hospital is. Similarly, they might be referred to the cardiac rehabilitation team or the myalgic encephalitis and chronic fatigue service team, if their main symptoms are fatigue and brain fog.

Rather than moving to a pure long Covid service, we are now looking far more at a multidisciplinary assessment followed by the utilisation of existing services. That is driven partly by geography, and partly by staff shortages; there are simply not the additional staff with the appropriate expertise to run a pure long Covid service without taking anything away from other essential services in our health service.

The Convener: Thank you. We move to questions from Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning to the panel. I want to follow up on some of the issues that you have highlighted. I was interested to hear that the three of you are putting forward three different approaches.

As a committee, we have found that, when we speak to long Covid sufferers in Scotland, there is a persistent theme coming through. They feel that the services are not there to support them, and a lot of them have latched on to the notion of long Covid clinics, which we do not currently have in Scotland, as a solution. However, we have also seen some evidence to suggest that those clinics have quite a mixed response from patients, with people complaining about long waiting lists or appointments being available only remotely rather than face to face. I would like to understand from each of you how your approach is positive and is working; what the pros and cons are; and what evaluations are being done of the patient experience.

Dr Heightman: We had ring-fenced funding available, which was a real enabler for setting up something new. However, as we learned more about the condition and understood the breadth of different inputs that individuals need, the vision grew.

As the committee has heard, we all have slightly different models in our own systems, but they are all trying to achieve the same goal. That is where our post-Covid network—if we can call it that—acts as one team in a joined-up way, taking decisions around the patient. That avoids people experiencing multiple onward referrals in a scattergun approach, which is an awful experience for patients.

It is also, with a new condition, about learning together. In 2019, I did not know how to manage the condition—I did not know that it existed. Through 2020, we learned at pace, but that was only through learning together with other specialists and a broad range of therapists. That process has not ended, and there is still a lot that we do not understand about the condition. We need to do lots of research, and we are just learning now what the most effective strategies are.

For me, the concept of a post-Covid service is one that sits at the interface between primary, community and secondary care and can draw in all the elements that the individuals need. There will be different ways of making that a success, depending on the region where you are working, because the geography, in particular, is very important.

That is where we are at but, in many services, we have seen very exciting innovation, which will bring transferable benefits to many other long-term conditions. As we try to transition to a more business-as-usual model in England, we are starting to think about what elements have been very successful and what we must keep going forward after this year of funded services. There is a lot of potential.

Murdo Fraser: Before I bring the other witnesses in, can I ask whether you have involved sufferers of Covid or long Covid in the design of the plans?

Dr Heightman: Yes. The lived-experience partners have been a key part of the national programme in NHS England and have co-designed the commissioning guidance and the plan for improving services. It is also very important to have a strong lived-experience voice at the regional level, because you need to look at the granularity of what you are offering. That is challenging for people who have severe fatigue, but it is something that we will really encourage as we move to that business-as-usual model.

The patient experience is variable, so we hear quite negative reports from some patient groups, and other surveys—for example, by Ipsos MORI—have described the barriers that people are experiencing in accessing care, as well as their dissatisfaction with virtual support, which I completely agree with. I think that it is very difficult to manage somebody with long Covid entirely virtually. Given that we are all back to having face-to-face appointments, it is hard to justify that, so we have to listen to that negative feedback, but there is also some lovely positive feedback on situations where the model is working well.

Dr Strain: Like Mel Heightman, we have involved our patient partners from the outset and kept them coming in, and that has been a major part of our recent redesign of the service.

One of the barriers to providing an optimal, consistent service is a lack of knowledge. We genuinely do not know the natural history of this disease, because it did not exist three years ago. There has been a dearth of research into the most similar disease to it, myalgic encephalomyelitis, so we do not yet have an understanding of that similar condition. Where there are similarities, we are utilising existing services, so those people who have severe Covid and have been hospitalised are being followed up in exactly the same way as anybody else who has a post-intensive treatment unit syndrome, and are receiving the same management.

The lack of consistency is—[*Inaudible*.] There just is not a defined or proven treatment yet. As the research comes through, I hope that we will start to see defined treatments and get better ideas, so that we can generate a consistent approach going forward.

Claire Jones: As we know, long Covid does not sit under a single specialism. We have seen cardiac, respiratory, neurological and gastric issues so, without a service in place, patients report feeling abandoned or passed from pillar to post, with referrals to multiple specialisms and long waiting times. Therefore, co-ordination of care and case management is another key approach that is fundamental for such a complex and multisystem condition.

We know that there have been calls for long Covid services in Wales to be in the form of consultant-led clinics, and I was pleased to hear Dr Amy Small's take on that last week. Those clinics are expensive, and who is going to staff them? We do not have an abundance of consultants from a variety of specialties who are available to run clinics for long Covid. More importantly, our argument is that that model is not always necessary. With our model, we have a variety of skills within our team. I am an advanced practitioner and I have worked with cardiac and respiratory patients for years before setting up this service. I had experience of working with patients with postural tachycardia syndrome—PoTS—and I was fortunate to work and learn from a cardiologist who had an interest in PoTS.

We have a GP with specialist interest in long Covid, other allied health professionals and the psychology team. Dr Amy Small highlighted that having all those things allows a team with those skills to assess and manage symptoms from within that service, rather than having to refer to all the different specialties or having them all in a one-stop clinic that is run by one consultant from one specialty. We think that our model works because our service is staffed with the correct skill set and the correct mix of MDT professionals.

10:00

We are able to do what Dr Amy Small suggested last week. We organise diagnostics and review results from within our service, which avoids the need for secondary care referrals in the majority of cases. We already work collaboratively with secondary care colleagues, which ensures a smooth pathway for onward referrals where necessary and diverts unnecessary secondary care referrals in some cases.

In short, we feel that we are doing what the consultants would do in their clinics for cases that we can, and without the good pathways and communication between the services, that would not be possible. In relation to the differences between services, those are the things that I feel need to be worked towards.

For anything that we cannot do, we of course refer directly to specialists. We discuss cases on a weekly basis to ensure that we do not miss things and do not do anything that specialists would not do if patients were being seen in their clinic.

We are able to offer medical treatment where indicated to treat some of the symptoms of long Covid such as PoTS, as I mentioned, as well as management of co-morbidities and risk factors for other chronic diseases. Importantly, we provide a comprehensive biopsychosocial group programme to support self-management. Its interventions are focused and solution based, and it includes things such as vocational rehab, support with managing cognitive difficulties, support with coping with fatigue and sleep difficulties and support for improving emotional wellbeing and coping with this difficult condition.

We also offer practical breathing sessions and gentle, individualised, mostly seated strengthening exercises to support activity and avoid the risk of post-exertional symptom exacerbation. We are very careful with recommendations for exercise, because for many people with long Covid, it is not appropriate and can in some cases be harmful.

Truly supported self-management is not only about education—we are not sitting there preaching at people and telling them that they need to take their time and breath properly. It is about engagement, listening and individualised support. As part of those group programmes, we provide personal one-to-one sessions interspersed with the group sessions to allow space and time to provide individualised support to embed those practical interventions from face-to-face sessions.

The term "rehabilitation" comes up a lot, but some people do not like that term when it comes to long Covid. Rehabilitation can mean different things to different people, but this is rehabilitation. Rehabilitation does not just mean exercise; it should be holistic and values based, and it is about finding the strategies to help people live a fuller life. That can be done alongside the medical treatment of long Covid symptoms.

The second part of your question was about evaluation and patient experience. The adferiad funding—“adferiad” is the Welsh for recovery, as in Covid recovery—has been utilised to carry out an on-going all-Wales evaluation project, which includes use of a health-related quality-of-life questionnaire called the EQ-5D-5L, as well as collection of patient experience data, case studies and local data.

Although it can be difficult to evaluate services because of the nature of long Covid—people can have relapses and their symptoms can fluctuate over time—the analysis suggests that quality of life is good. Feedback collected from patients at the point of discharge was higher than that collected at the point of referral, and the service user experience was generally positive throughout the data collection period.

Within our service, we also collect real-time feedback, which includes patient experience. That is also predominantly positive, particularly in relation to the themes of feeling well supported, listened to and believed about their symptoms. That is very important.

Dr Strain: I forgot to mention one other element, which came from people with lived experience. Providing a single point of contact for every patient who had been referred was absolutely essential. Very often, patients end up experiencing multiple different specialties, so they might end up seeing different people. One of the complexities that people face, particularly those who are struggling with post-exertion malaise, fatigue or debility or who have difficulty focusing, is navigating the health service and knowing whether they should see their cardiologist or respiratory risk team.

The most important and best feedback that we received was that every single patient going through the system should have a named individual as a core point of contact to act almost as their liaison between the different specialties. For the most part, that will be the therapist. The use of occupational therapists and physiotherapists has been absolutely tremendous, and they have been essential—indeed, they have been right at the core of our service. It was the single most important step that we took to modify our service and to ensure that everybody had ease of access. That person also became the individual’s advocate at other MDT meetings that we hosted.

Dr Heightman: On the question whether there should be consultant-led or community-based services, I have to say that that does not need to be an either/or. You can have a win-win by having both. However, consultant input can be very efficient. For example, we fund four hours a week of cardiology time; that serves our population of 1.6 million, but the efficiency involved in that is that the individual is a post-Covid cardiology expert, and they give us all the safety and confidence that we need to manage patients in a consistent way.

That was just a plug for taking an approach in which we do not leave our specialists in hospitals to deal with our ageing population, multimorbidity and other complexities. We need to bring them into the community, and you can do that in a lean and efficient way.

The Convener: I call Alex Rowley.

Alex Rowley (Mid Scotland and Fife) (Lab): Thank you very much for speaking to us this morning. You have all talked about tapping into and referring to other services, but has any specific funding been earmarked for post-Covid and long Covid services? If so, is it recurring funding? How available is it?

Dr Heightman: The £90 million of funding each year is for assessment and treatment—that is, the rehabilitation that we have been hearing about. In my system, for example, more than half the budget goes on rehabilitation; it is the key part of treating this condition proactively. That is absolutely what the funding is for.

As for the future, long Covid is very much a moving target; it is difficult to know how much NHS finance should be invested each year, and we do not have completely perfect data with which to guide decision making. Funding has been renewed for 2023-24, and, from 2024 on, we want to see how commissioning can be transferred to integrated care boards alongside their business-as-usual approach. As for the decision whether additional funding will continue as part of that process, I do not have an answer at the moment. The issue is being worked through this year, but I hope that that will be the case, given the benefits that we have seen with the dedicated model.

Dr Strain: I am under exactly the same remit as Mel Heightman—after all, we are in the same NHS. However, when it comes to providing services, we have used our funding in a slightly different way. Like Mel, we have bought time from different places; however, the biggest problem that we face is a lack of staff who are able to do this. The money is there, but, if you use it, you necessarily take it away from somewhere else. There are just not enough community rehabilitation teams, whether we are talking about physios, OTs or psychology support; in fact, we recently lost our psychologist when she went to another team.

The bigger problem that we face, therefore, is the staffing model rather than the funding. Hopefully, though, it will be recurring funding, and we will be able to establish this as an integrated, community-based, rehabilitation-focused service. However, the key element is staff. I am not going to reiterate what we are doing in the south-west, because we face the same challenges that Mel Heightman is facing in central London.

Claire Jones: Obviously the situation is different in Wales. From 2021, the Welsh Government has been providing a fixed-term £5 million package of support for the adferiad programme to expand the provision of the diagnosis, treatment, rehab and care of people suffering from the long-term effects of Covid.

The health boards have been extremely pleased to hear that there has now been a commitment to recurrent funding from the Welsh Government. The Minister for Health and Social Services will shortly make a written statement to announce that. That funding commitment will strengthen those community-based services by allowing an expansion of capacity and a widening of the access model to people who have other medical and long-term conditions but similar symptoms and needs to those who have long Covid.

We want to provide prudent healthcare, share resources and help those patients who currently fall through the gaps and do not fit into any particular service to access and benefit from the services that we have been able to provide.

When the funding was not recurrent, we had the issues that Melissa Heightman and David Strain have talked about. We were not able to spend the money because we were not able to recruit to temporary positions. It was a challenge. That has led to longer waiting times than we would like or are acceptable, so we hope that the recurrent funding will mitigate that. We have certainly had more interest in posts that we have advertised as permanent, so I am confident that recruitment will be successful.

Alex Rowley: All the NHS boards in Scotland report recruitment issues with specialist posts such as rehabilitation co-ordinators, occupational therapists and physiotherapists. You have kind of answered that, but the question then is how sustainable it is to say that we will offer those services, and what needs to happen, given that there is recognition that the number of people being reported as having long Covid is quite high. That must put masses of pressure on the system. What do we need to do?

Dr Heightman: Those people need care. They will access care and will use the NHS. Either they use it ineffectively, with poorer outcomes, or we give them access to a model of care that is efficient, gets the best outcomes and continues to learn about how to improve. As we have heard, there is definitely potential to align those services with other conditions, where needs overlap.

Given our workforce constraints, we have to look at skills transference between individuals. A lot of progress has been made on that when it comes to long Covid. People’s cases are now managed by either a physiotherapist or an occupational therapist, and we are bringing more nursing support into the workforce teams. Transitioning that to the level of integrated care boards will be an opportunity, because those will be looking at the needs of their local population through the lens of population health and health inequalities and—I hope—will start to expand the rehab offer for people who have other complex multisystem diseases. That might be a way of growing the sustainability, if you see what I mean.

Alex Rowley: I have been surprised by the number of people who have written to me to say that they have been suffering from ME for years, that it has been really difficult and that they have not been getting support. A lot of conditions seem to be similar.

Dr Heightman: Exactly. The needs overlap.

Alex Rowley: Dr Strain, do you have any points to make on how we tackle sustainability?

Dr Strain: We still do not have clarity on the underlying causes and natural history of long Covid. However, as you have highlighted, the similarities with ME suggest that a significant proportion of the long Covid population will not get better without some additional support. It will be a long-term need, and it is important to distinguish the patients who are suffering from such long-term diseases.

I am a geriatrician. We are used to community working and to providing holistic input from the outset. However, to be blunt, given that we work with people of 70 or 80 plus, geriatricians work within a limited timeframe. If, through long Covid, we have created a whole generation of 20 and 30-year-olds who suffer from that long-term disease, if we do not get it right—rapidly—we will instil a long-term illness, manifestly, into them. That will put further and increasing pressures on to the health service, not just for three or four years but for the 20, 30 or 40 years during which those people have increased needs. It therefore becomes a priority to get it right for those patients.

We hope that people with those other allied diseases—conditions with a very similar natural history—will also benefit so that we can have a healthier society and tackle some of the other issues that are out there.

10:15

Alex Rowley: Claire Jones, do you have anything to add?

Claire Jones: I do not have much to add. There is capacity, at least in our system. There is so much duplication already in services that have existed for a long time—condition-specific services, such as cardiac rehab, pulmonary rehab and pain services—and there are many patients with overlapping needs. We can avoid duplication by working smarter and collaboratively and by looking towards multimorbidity rehab models, through which patients are able to access one service instead of, for example, going to one service if they have chronic obstructive pulmonary disease and a separate service if they also have heart disease. Let us not duplicate things—let us work together and work smarter.

There is a service in Scotland that has a very good model for multimorbidity. It has been leading the way on that, and we would like to replicate it as an extension from this programme in Wales.

Stuart McMillan: David Strain, you mentioned the single point of contact model and how that has been beneficial. Has it also been beneficial for people with a variety of equalities issues, whether that is people from the Traveller community, people with visual impairments or people with learning disabilities, for example? How has the process worked?

Dr Strain: The first thing to say is that Devon is not a particularly ethnically diverse community so, compared with the populations that Mel Heightman serves, the populations that we serve are relatively non-diverse. Therefore, we face fewer issues in that regard.

We took the single point of contact model from our ME service. Particularly for people with learning disabilities and those who might be differentially advantaged due to their socioeconomic status, the single point of contact has been essential. For example, those people might not be computer literate and, therefore, might not have the ability to do video consultations. A key component of the service has been the use of simple phone calls, which would always be from a person who the patient would be able to recognise and whose voice they would know. One of the difficulties has been establishing boundaries, which we have managed to achieve really effectively; that appears to be the way that we have addressed some of those issues.

There will always be problems. The Traveller community as a whole has not reached out to long Covid services, but a big part of that is its engagement with the health service overall. We need to make our service—not just the long Covid service but the general health service—far more accessible to those individuals. That work is on-going. Again, that is not specific to long Covid and is a health service-wide failing, and we need to make the service far more accessible on those grounds.

The simple answer to your question is that the single point of contact—a familiar voice at the other end of the line—is doing far more than anything else that we have done to improve satisfaction with the service.

Stuart McMillan: Mel Heightman, what area do you cover?

Dr Heightman: I work in north central London. In that patch, we see patients from the most deprived backgrounds and the wealthiest; there is a massive range. However, in our clinic cohort of 4,000, people from the most deprived postcodes are underrepresented. We now have a live dashboard, which allows us to do a bit of a deep dive into our local population, and we can see entire postcodes that are completely left out, in the sense that they are not diagnosed with long Covid and are not referred to services. We are trying to map that against local communities, and there is massive ethnic diversity. We have a real problem. I have never seen anybody from a prison, and we see very few people with learning difficulties. There are certain ethnicities in our local catchment population who are not coming forward to the clinic.

We need to engage with our community in a different way. It is not just about having a barrier in primary care. Indeed, I do not believe that that is where the barrier really is; I think that it is in individuals' understanding of what a long-Covid illness is. Help is available, and that help will encourage their recovery. The treatments that we offer work. That is another really important message to get out to people: this is not a hopeless situation.

The work on the ground is quite challenging for us in the service. We have recruited GP leads in each borough to help us with the outreach programme, and we have done a lot of training with the voluntary sector. At the moment, however, that has not really borne fruit, and we need to keep thinking about how we can solve that problem.

Stuart McMillan: Would a single point of contact be useful for your area?

Dr Heightman: We have that. We have two brilliant nurse navigators, who are really important for helping patients to understand what tests are happening next and what their current treatment plan is. We are currently looking at self-referral from particular communities, ensuring that we work in a focused way and managing the risk as well as possible.

For most people, the GP referral route is very important and works well. It allows the GP to join up all their other elements of care. The self-referral option might need to be implemented in some communities.

Claire Jones: I echo what has been said. We are in north Wales, which is not particularly ethnically diverse, but there is a wide range of marginalised groups. We have a very large prison in north Wales, but we have not had a single referral from there. We are looking to target that.

Accessibility for marginalised groups has already presented itself as something that needs to be developed further. Very few patients from marginalised groups have accessed services compared with what we might have expected to date, and we have been taking steps to initiate appropriate engagement with those groups to ensure that the service is accessible. That work is on-going. We have been communicating with a range of experts in the field of engagement with difficult-to-reach groups. That involves a range of stakeholders from our equality and inclusion team. We have a huge variety of strategies proposed to promote those engagements.

There are lots of important things to explore. A single point of contact would definitely provide support with that patient group.

Stuart McMillan: I have chaired the Scottish Parliament's cross-party group on visual impairment since 2011. Throughout the Covid period we would meet online, and the issue of the level of contact came up a couple of times in our meetings.

On wider engagement, it might be worth while engaging with the third sector and some of the charities that deal with people with visual impairments and those with dyslexia, for instance. It is highly likely that they will have better opportunities to engage with the people whom you need to engage with, and that they can assist you to do what you need to do.

In answer to a question from Alex Rowley, Claire Jones talked about people feeling supported. I met up with constituents who are members of the local long Covid support group a few weeks ago, and that issue came up with regard to employment in particular. I am not suggesting that any of the three of you should be engaging with employers in the areas that you represent, but has the issue of people being worried about their employment come up in discussions? Has it created additional worry or stress for individuals who want to get back into work?

Claire Jones: Yes, definitely. That is a huge issue. Our own staff within our health board make up a huge proportion of our patients. That includes people from the social services sector and people who work in public services.

The support that people receive with returning to work, and in the workplace, varies so much. Long Covid is still very poorly understood among employers, and that is another avenue that we are trying to explore. We invested in the appointment of a co-production lead, which has allowed us to focus on those issues and do some engagement work. We want to provide training in our area for very large employers in particular, whether they are in the public or private sector. That is about helping employers to understand the nature of the condition—for example, that it is not the type of condition that enables what we would think of as a standard phased return, in which someone is expected to gradually increase their hours or duties week on week.

A flexible approach is needed, but for the majority of patients, that is just not possible—it is not being made possible by their employers. I know that flexibility can be difficult; it depends on the employer and the nature of the business. Nevertheless, employers should be more flexible, and there should be a way around that. We have seen so many patients with long Covid sadly lose their jobs, and it is heartbreaking to see the effect that that has when there are actually strategies that we think can work.

It is important to engage with employers. As you say, we cannot tell employers what to do, but with guidance, they should be able to support people better than they are doing now in most cases.

Stuart McMillan: Mel, has that come up as an issue where you are?

Dr Heightman: Yes, it is a huge issue. Two thirds of the people that we see are unable to work. In addition, 10 per cent of our patients are NHS staff, and that is replicated in the national registry across many services in England.

One of the areas of rehabilitation in which we have invested is vocational rehab. It has highlighted a real absence of vocational rehab for people of working age in our community. That programme is getting really good results—60 per cent of people whom it sees are getting started on a phased return to go back to work. From an economic perspective, therefore, it is important that we do that well.

We are trying to expand the vocational rehab programme in north central London. We have had some charity funding to develop a bespoke programme for NHS staff in London because they need a particular focus on the phased return aspect. We do a lot of negotiating with employers—that takes up a lot of the team's time. I am sure that Claire Jones and David Strain have the same experience.

Dr Strain: I will not repeat what Claire Jones and Mel Heightman have said, but we would echo that.

I will put forward a health service viewpoint. In my BMA role, I receive a lot of comments on this. Healthcare workers have a much higher risk of contracting Covid than the national average through their activities on the front line, and they have also ended up with far higher rates of long Covid than one would have anticipated. We believe that that may be something to do with the pressure to return to work.

The BMA did a wide-ranging survey. I stress that only doctors were surveyed, but I suspect that the picture among nurses and therapists alike will be very similar. The results suggest that across England, Wales and Northern Ireland, as well as Scotland, approximately 7.2 per cent of doctors are suffering on-going symptoms of long Covid, and 5.3 per cent have had long Covid but have managed to make a sufficient recovery and have returned to work on their normal hours. Approximately 20 per cent of those who responded to the survey have required to take sick leave at some point during their long Covid, and 10 per cent of them are still working reduced hours as a result.

A substantial number of doctors have lost their jobs as a result of the loss of special Covid leave and their on-going problems from Covid. You have already heard from Amy Small, who told a specific story about how she has been affected, and she is not unique by any means. We have literally hundreds of doctors—and, I am absolutely sure, hundreds of nurses and therapists—who are suffering with long Covid.

There are further issues. The UK as a whole is out of step with the rest of Europe, in that we do not regard long Covid as an occupational disease, even though there was very clear occupational exposure. As it is not designated as an occupational disease, there are no means by which to offer any sort of compensation—or, for that matter, even disability support—for people who have lost their jobs.

10:30

That needs to be addressed rapidly. The pressure of not knowing whether you will be able to feed your family or pay the mortgage is an additional stress that people with long Covid can live without. It will be a barrier to their returning to the fruitful work that they wish to be doing. Everybody with long Covid whom I see in clinic wants to return to normal, but the pressure of not knowing how that is feasible from a purely practical point of view is an additional barrier to their getting better and it needs to be addressed rapidly.

The problem with accessing disability support is that it requires a specific test to receive it. That is not easy to achieve, particularly for somebody who is suffering with the brain fog, fatigue and symptoms that a lot of our patients experience. Therefore, some simplified core route that enables people to get through that and helps them to navigate those challenges will ease the mental burden on them and allow them to focus purely on their recovery.

Mel Heightman highlighted the degree of support that we can offer to healthcare workers and Claire Jones perfectly highlighted the individualised approach that is essential. That brings us on to the aspect of educating employers. We can all do more to work on that.

The Convener: I am conscious of time and we have two members to go. Brian Whittle, would you like to come in?

Brian Whittle (South Scotland) (Con): Good morning, panel. Thank you for coming and sharing your experiences.

When we speak to long Covid sufferers, the theme that comes out is a long journey to get to a diagnosis and then to get through treatment. The diversity of symptoms for long Covid seems to require a process of elimination. They get electrocardiograms, MRIs and blood tests. All the other conditions that put the NHS under pressure have not gone away.

It strikes me that one of the keys to streamlining and making efficient the diagnosis and treatment of long Covid is how we gather and use data. Are we gathering data? Do we have an information technology system that allows the deployment of that data?

I am looking at your responses, Dr Heightman, so I will start with you.

Dr Heightman: It is a clinical diagnosis and you get better at making it when you have experience. That is why those services are important. You do not need to have all the tests back and exclude all other causes before you use the label—that is where we are going wrong. We can use it while we are excluding other causes.

On data, it has been difficult to know how many people are affected by long Covid and to measure how well we are doing against that need. The Office for National Statistics Covid infection survey, in which people self-report a long Covid illness, has been the best source of information. The ONS estimates that 3 per cent of the population is affected. We do not know what proportion of those people need to access NHS care, but we estimate that it is about a fifth of them, because that is the proportion who report that they are significantly affected.

We have that data source and, in the England clinics, we have to submit data returns at patient level every two weeks, so we have a national registry of all the patients who have been seen. That is a hugely important learning resource because those are people with a clinically validated diagnosis, not just those who self-reported. It enables us to start to consider equity of access and those individuals' healthcare use. However, we have learned in our system that if you really want to dig down into the health inequality aspect, you have to partner that with live information about who is being coded in your primary care practices and your referral rates by different GPs. Coding is an incomplete, imperfect process in primary care. I have got the data that I need only through being part of a research programme, but it has been a massive enabler in helping to tackle the health inequality issue.

I would love to have the same dashboard for all the long-term conditions that I manage in our local system. It is another area where there has been some innovation, and we should learn from where it has worked well. In general, however, we do not have the data that we need to know how to plan well.

Brian Whittle: I ask Claire Jones the same question. Perhaps you can give us your experience from Wales.

Claire Jones: My experience has been similar in respect of the difficulties with coding and diagnosis.

With regard to recording information, there is something to be said about whether we need a national registry for patients who are attending the services. That could potentially provide support and help to record services and prevalence, and help with diagnosis.

However, it could also potentially exacerbate the risk of diagnostic overshadowing: not investigating new symptoms that patients with a diagnosis of long Covid might present with because it is felt that their symptoms are explained by their long Covid diagnosis. For example, one might see somebody with a new onset of chest pain. Speaking from experience, we are having referrals rejected because the response is, “Well, they've got long Covid, so that explains it”, but it does not explain it. A number of people with long Covid will still have other conditions, cardiac events and serious health problems, which will present themselves and have symptoms that overlap with those of long Covid.

Raising public awareness about that, and avoiding it, is important, in conjunction with recording the data and sharing it and, if we were to have a database, thinking about recording information about long Covid.

Brian Whittle: I will expand the discussion to Dr Strain. From a BMA perspective, with regard to data collection and deployment, where can we learn from, and where could we improve the system?

Dr Strain: I will answer that from a research point of view first, before I move on to the BMA's perspective.

I am engaged in one of the biggest primary care network research programmes in England—I apologise for the fact that it is in England. It has access to 25 million patient primary care records. Looking purely at the codings on those records, one of the biggest predictors of having a code for long Covid is somebody's locality or their proximity to the nearest long Covid service. When we went back and looked at that in retrospect, we saw that as new services were set up, new diagnoses of long Covid suddenly started appearing in the primary care records.

That lends itself to the idea that using primary care records to try to predict where we needed the service did not quite work, because although GPs were recognising long Covid, they may not have been using the appropriate coding and tools in order to note that. If there is no service and no ability to do something about it, putting a code in is simply yet another task for a GP who may be bogged down with 101 other issues.

Broadly, the British Medical Association wants to be using healthcare records to improve healthcare planning and services in the future across the board, and across the whole of the UK. We have a tremendous resource sat there.

However, on-going concerns remain about who has access to that data; what the risks of freeing up patient data are; and ensuring that absolutely nothing acts as a barrier to the trust between a patient and their doctor. There is always the fear, in particular where there have been thoughts of private companies managing the NHS private network, that the relationship between doctors and patients might break down if people are worried that some big American conglomerate has the potential to look even just at the coding of those things.

That has to be thought about with great care before we start moving forward to a fully integrated, centralised platform in order to do what we have discussed. The potential is tremendous, provided that the information stays in the control of the NHS itself rather than going to external sources.

Brian Whittle: I will reverse a wee bit and ask you to clarify one point that you made. Are you suggesting that the ability for a GP to point to a long Covid service actually dictates where long Covid diagnoses are likely to spring up?

Dr Strain: We looked retrospectively at the coding records in different regions before and after their long Covid services were set up, and the symptomatology had been there already—patients were presenting with fatigue, breathlessness and shortness of breath—but the codes had not made it on to patients' records. As soon as a long Covid service was available, the same symptoms would be there as the primary symptom, but the records would also note that long Covid, or post-acute Covid syndrome, as it was called originally, had been presumed, suspected or considered. The availability of a long Covid service was the best predictor of having a specific long Covid code.

The reason I say that is not to suggest that the diagnosis suddenly rocked up around the service; it is just to show that GPs are incredibly busy dealing with the problem that is in front of them, and when they cannot do anything about long Covid, getting the coding right for it is less important than dealing with the symptomatology of the patient who is in front of them, there and then.

The reason that I said that is because when we do a big trawl of GP records, we should be cautious about saying that Aberdeen, for example, has a lot of cases of long Covid or that it has no cases of long Covid and therefore there is no point in putting a service there.

Once services are in place, or once the ability to provide the right management is in place—and I stress that I mean the ability to provide management, rather than provide a service per se—that is when the coding will improve. Historically, that is when it improved in England.

Brian Whittle: The outcomes from the development of long Covid clinics are not only about the ability to diagnose and treat. Does that mean that long Covid clinics are a conduit for gathering that important data?

Dr Heightman: Absolutely. Often, the clinic confirms the diagnosis, so it is only after the patient has been to the clinic that the GP assigns the code with confidence. That might be part of what is going on.

Clinics are a key resource for understanding the epidemiology of the condition and for getting patients access to research trials of treatments and underlying mechanisms, which is really lacking at the moment. Only one trial of treatments is running in England. It is looking at repurposed medicines—David Strain and I are involved in it. We would love to be able to expand that platform.

The void in the understanding about mechanisms and treatments is putting patients at risk, as they are seeking so-called miracle cures by travelling abroad to foreign clinics that are claiming benefits from certain treatments. We have not seen evidence of that, but we are all very concerned about it.

Brian Whittle: I will conclude my questions by expanding on the collection of data. I will put the question to Claire Jones first. What ability do you have to share and collect data—not only from around the UK, but internationally, given that this is a global pandemic?

Claire Jones: Do you mean for the purposes of research, or just general data around long Covid?

Brian Whittle: We are trying to get to a position where we are as efficient as we possibly can be in the diagnosis and treatment of long Covid. Presumably, the more data that we can pull from the global population, the more that would aid you in that.

Claire Jones: Definitely. Pulling in as much data as possible will support the research on which treatments are working, which ones are not working and which interventions are being provided in different places. Such data would contribute to the research base and help us try to figure out what will be helpful, as would sharing and disseminating that data.

Brian Whittle: Dr Strain, do we have an IT system that is capable of pulling that data in and usefully using it to develop treatments and diagnosis?

10:45

Dr Strain: The technology is there. The system that I am engaged with lists coded information that is anonymised at source, and it can track what has been trialled for those patients and track their records. To go back to Mel Heightman's comments, having a central source to get into that data is essential so that we know about people with long Covid once the diagnosis is confirmed. The network that has been set up around the long Covid clinics has been key to getting that right in England.

That is not the only route. If we can get the coding right in the primary care network and track what has been trialled through the existing system—we have the infrastructure in place that can do that—that will be another route. However, one of the key deficits remains the understanding of the mechanisms and what goes on there.

If we had a simple diagnostic test, as we have for diabetes—we check sugar and HbA1c, and we can say, "You've got diabetes"—long Covid would become really easy to track, but we do not yet have that. People were, and are, working on that, and as soon as we have it, it will be a transformational change. That has real potential, and I think that it will be the thing that determines the best treatments as we move forward, once we understand the mechanisms and have the diagnostics there.

The Convener: I am conscious of time, and John Mason wants to come in. In fairness, we can go up to 11 o'clock.

John Mason (Glasgow Shettleston) (SNP): Thank you, convener—I am pleased to take part in the session. For interest, I note that my constituency is in the east end of Glasgow, which is generally seen as one of the poorer areas of Scotland.

I will build on some of the previous questions. GPs have been mentioned quite a lot, and the theme of my questions is how we share learning. I get the impression, certainly in Scotland, that one or two GPs are specialising in long Covid and are into it 100 per cent, while other GPs are clearly less familiar with it.

We can start with GPs—and perhaps start in London—and then move on to other aspects. How does that work in practice? Are GPs being given information from the top down, or do they share it with each other? Is there a consistent approach to informing GPs?

Dr Heightman: We had an enhanced service programme in the first year of the clinics, when there was a small amount of funding to primary care to incentivise coding, case finding and referral, but we did not hold practices to account on that. One could argue, therefore, that we perhaps did not reap all the benefits of that process.

The Royal College of General Practitioners has produced some brilliant training webinars and e-learning content. However, working within the system, I have seen that we need to invest in GP leadership in long Covid. We use our post-Covid moneys to appoint a GP lead in each borough; they know how to engage with primary care and, in partnership with that GP, we deliver additional training. We have been going into practices and holding virtual MDT meetings to which GPs can bring patients for case discussion. That is very efficient—we can talk through 20 patients in a one-hour meeting and work out whether someone needs referral.

There are a number of options, but the GP is key to that pathway. GPs are under immense pressure, however, and we have to do everything that we can to support them in respect of training and process. For example, we have developed a template in their electronic health record that allows them to do a quick long Covid assessment and generates an automatic electronic referral, in order to save them time and encourage them to use the pathway. We need to feed back to them on what outcomes their patients are achieving through accessing that care, in order to prove that it is worth referring people to it.

John Mason: Can I ask about Devon, Dr Strain? Are the GPs there more consistent in their approach than is the case in Scotland?

Dr Strain: The biggest problem affecting GPs is the workload that they currently face and the requirements of dealing with not only long Covid but everything else.

As you highlighted, we have some fabulous GPs—sorry, that is not true; we have loads and loads of fabulous GPs—but when it comes to long Covid, some have really taken it on. They have upskilled themselves, and we are utilising their skills and knowledge base in the management of our patients. They are interacting closely with MDTs. We are also learning from them about some of the things that they are trialling in the community, in particular in more remote regions. That engagement is there.

I do not want in any way to minimise the contribution of GPs who have not upskilled themselves in that way, as some GPs have only had the time and capacity to do that upskilling by effectively passing on some of their other responsibilities to their partners and colleagues in their practice.

Not every GP needs to be an expert in everything. The whole concept of GPs knowing everything about everything cannot exist in today's medicine. I am talking not about full specialist interests but about having different, flexible degrees of specialties and, importantly, GPs networking among themselves so that they know to tell a patient that they are probably not the right GP to look after them and to suggest that they see a different GP. That is about generating a degree of professionalism among GPs, for want of a better term. We are indeed seeing the same things as you, and we are utilising that.

On the point about providing an educational package, all GPs across Devon get together every two months for educational packages, some in person and some virtually. Long Covid has featured quite a lot in those. In fact, Mel Heightman has recently been down to Devon to chat with some of our specialists there. I am doing lots of our local educational packages, and we are getting the message out. All GPs have an awareness of the condition and some are developing a specialist interest in it.

John Mason: Ms Jones, is there also an idea of a network of GPs in Wales?

Claire Jones: We have a number of GPs with specialist interest in long Covid who are excellent, and I think that they link in with the network in England. A couple of GPs here in Wales do that.

There is a lot of variation among GP surgeries here when it comes to awareness. There is a good level of knowledge about long Covid and the services that are available but, although most GPs know that there is someone they can refer to, they might not necessarily know what we do in our service or what we can provide. There is certainly further work to do on engagement and raising awareness.

We engage with GPs through attendance at cluster meetings to try to raise awareness, yet patients still come to us, sometimes via another route, saying that they have seen their GP, who told them that they did not know that our service existed, even though we have been up and running for a long time now. We provide guidance to GPs about how to refer, and we suggest tests to them that might be needed, depending on the symptoms presenting before referral. We need to focus on sharing information about what we do and what is possible within our service.

We want to avoid patients being given unhelpful information. The GPs are usually the first contact for them, so it is good to share education about what works but also about what is unhelpful. The prime example is graded exercise. It is not the answer to everything. Just being told to go and get on with it and to push through can be so damaging for patients with long Covid or similar conditions. We do not want that to be the start of the patient's experience—that they feel they are not being believed or have been given unhelpful information. There is a lot more work to be done on that.

John Mason: That is all very helpful.

Let us widen this out a bit. I wish to start with Dr Heightman again, if possible. How about sharing between universities, such as your university and Scottish universities, or even those in Germany or America? Is a lot of international networking going on around long Covid?

Dr Heightman: We have some brilliant national networks, including an allied healthcare professional network, which runs across the country, and NHS England supports a clinical network. We see a real need for a UK clinical society, so that we can have a home for sharing learning and research in this field. At the moment, we have to tag on to other societies, and we are not always very popular with them, so we need our own grouping, and we hope that we can stimulate discussion of that as part of the transition planning, so that we are not siloed between England, Wales and Scotland, which seems very odd.

Internationally, the World Health Organization has done some brilliant work on long Covid, and many UK clinicians are very much involved in that. We have done a lot of research linking up with the US, which has invested heavily in long Covid research although, in some ways, the Americans are behind where we are, because they do not have an established clinical pathway. To do good-quality research we need a functioning clinical pathway so that we know that we are studying the right patients.

There is so much more that we need to achieve in this area, but the first step could be to have a UK clinical society. We are trying to find a way to fund and resource that, and to build enthusiasm for it.

John Mason: Who would take the lead on setting that up?

Dr Heightman: The jury is out. NHS England is trying to support that process, so we have been speaking to the royal colleges. It is a matter of how we fund it. At the moment, we do not have any pharma or charity funding, because it is a new condition, so we might need to be a bit innovative about funding to start the society and make it sustainable. However, there is already a network of massively engaged clinicians across the UK who would be enthusiastic about the grouping. We need a lead. Perhaps David Strain.

John Mason: Is there anything else that any of you think we should consider that we have not asked you about?

Dr Strain: To go back to networking, as Mel Heightman says, tremendous informal networks are being brought together. As she highlighted, a range of specialties are involved in that. I am a geriatrician, Mel is a respiratory consultant, Ami Banerjee, whom we also work with, is a cardiologist, and we have rehabilitation specialists. Because we come from so many backgrounds, there is not a natural single home for us. It needs to be formalised.

As soon as we start to get treatments, that is where pharma funding will come from that can provide the back-end support for the network. We would be very keen to establish the long Covid society, for want of a better term, providing that the network can be provided.

The other thing to say is that Covid is not over. People are still contracting it and, even in a post-vaccine world, people who are contracting it are developing long Covid. We have just lost one of our registrars, who contracted Covid and, four months down the line, has not been able to return to work due to that, despite being fully vaccinated.

The fact that Covid is still a risk is not being highlighted enough to ensure that it does not become an on-going long-term problem. At the beginning, we could almost be excused for not realising the extent of it. Today, there is no excuse for the lack of messaging about the fact that it is still a problem. In some parts of the country, the prevalence of Covid today is higher than it was when we went into lockdown, but it is just being accepted. We fully appreciate that Covid is not causing tragic deaths, intensive treatment unit admissions and all the other things that were going on, but it is still triggering long Covid and the only way that we can avoid long Covid is by not getting Covid in the first place.

Claire Jones: To go back to sharing information, I have nothing to add apart from to agree that it would be helpful for the devolved nations to work together more closely to optimise the sharing of best practice and learning opportunities.

I stress the importance of early intervention with long Covid patients. The difficulties that we have had with recruitment, which we hope that we will be able to rectify with the recurrent funding and by filling posts, have ultimately led to much longer waits than we would like. They are definitely not acceptable.

The sooner that we can offer the support, the better. There have been longer waits than we would like for people due to the staffing problems and the delay in establishing clinics. We could have seen patients more quickly by offering shorter clinic appointments, but we feel that it is more important to ensure that patients are given adequate time in clinic to allow for a full assessment of their experience, needs and concerns and to address those fully.

Early intervention is vital to prevent long Covid from becoming an entrenched long-term condition where possible, as we have seen with other similar conditions. We need to learn from conditions such as ME/chronic fatigue syndrome. If someone is lucky enough to have a dedicated CFS service in their area, access to it often comes much further down the pathway, when it is more difficult to support issues that have become more severe and entrenched.

We hope that we will be able to overcome those barriers to allow us to reduce waiting times. We really feel that early intervention is crucial.

Dr Heightman: I agree about prevention. Vaccination reduces the risk. Most of our patients were unvaccinated at the time that they were infected—we must not forget that.

We must standardise our rehab programmes and start measuring the outcomes from them so that we know what good looks like. At the moment, they are too variable.

I absolutely agree on early access. Long Covid is a treatable condition. The sooner we see people, the better.

The Convener: I thank the witnesses for giving us their time. If they would like to raise any further evidence with the committee, they can do so in writing. The clerks would be happy to liaise with them about how to do that.

The committee's next meeting will be on 9 March, when we will continue our long Covid inquiry by considering study and research.

That concludes the public part of our meeting.

11:00

Meeting continued in private until 11:06.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba