

## **COVID-19 Recovery Committee**

### **6th Meeting, 2022 (Session 6), Thursday 24 February 2022**

## **Inquiry into excess deaths in Scotland since the start of the pandemic**

### **Introduction**

1. At its meeting on 18 November 2021, the Committee agreed to undertake a short inquiry into excess deaths in Scotland since the start of the pandemic. The purpose of the inquiry is to examine the extent to which excess deaths are caused by the COVID-19 caseload or the indirect health impacts of the pandemic.

2. The purpose of this evidence session is to help the Committee examine the pressures facing the NHS and some of the health impacts being experienced by individuals. The Committee wish to look at the level of demand facing services and trends in excess deaths which do not seem to be entirely explained by COVID-19 cases.

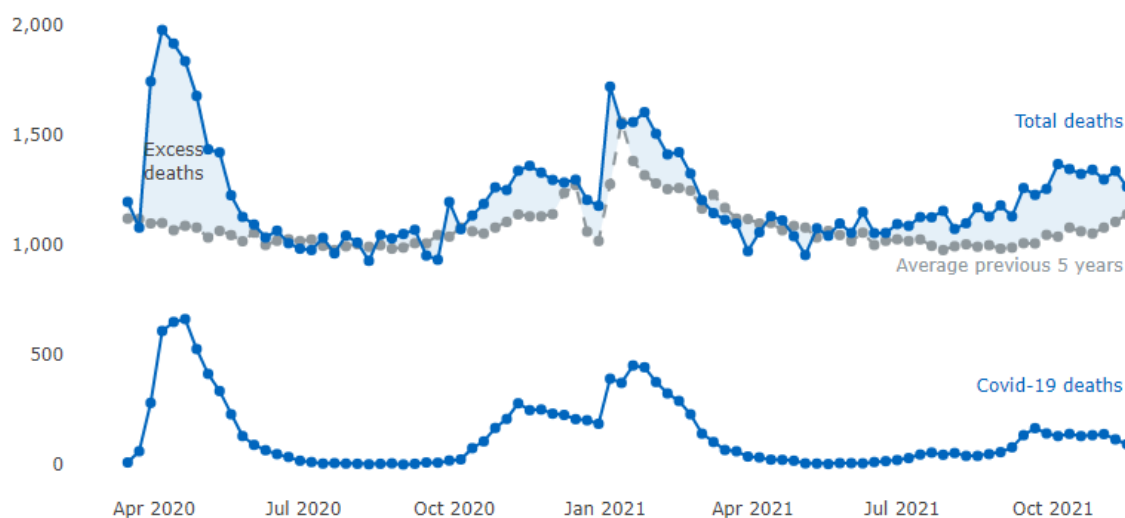
3. At this meeting, the Committee will take evidence from the following witnesses—

- Professor Andrew Elder, President, Royal College of Physicians of Edinburgh;
- Dr John Thomson, Vice President (Scotland), Royal College of Emergency Medicine;
- Dr David Shackles, Joint Chair Royal College of General Practitioners Scotland;
- Dr Barbara Miles, President, Scottish Intensive Care Society.

### **Background**

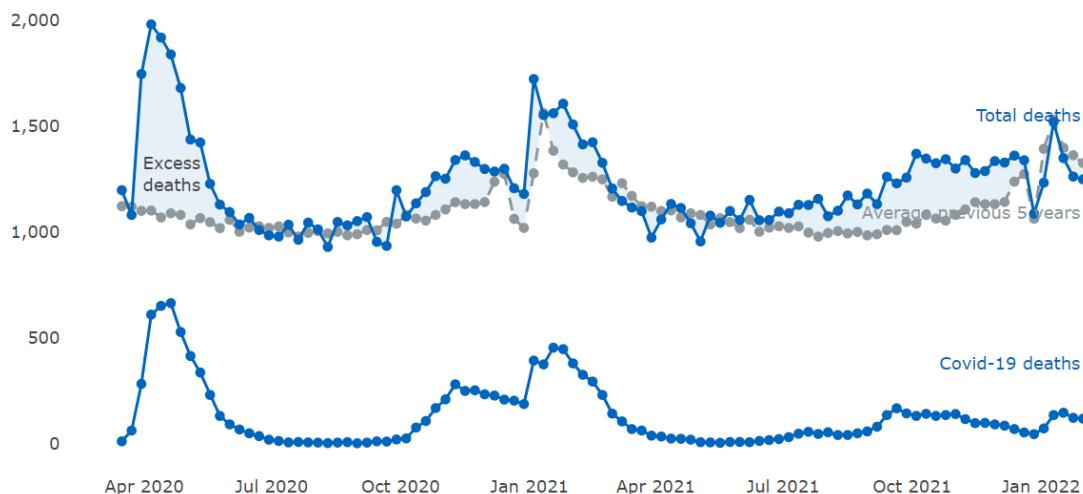
4. When the Committee launched its inquiry, data from the Scottish Government showed that deaths in Scotland were 11% above the average for that time of year and had been above the average for the last 26 weeks.

**Fig 1: Excess deaths in Scotland since the start of the pandemic**



Source: [Scottish Government](#)

5. The latest data published on 14 February 2022 shows that deaths in Scotland are currently 6% below average.



6. What is unclear, is the extent to which excess deaths are being caused by the COVID-19 caseload, or the indirect health effects of the pandemic.

## Evidence

7. The Committee issued a call for views which ran from 9 December 2021 to 28 January 2022. The Committee received 101 written submissions including submissions from the following organisations and academics—

- Age Scotland and About Dementia (joint submission)

- Alcohol Focus Scotland
- BMA Scotland
- Dr Christopher John Boitz MBChB BSc (hons) GP
- Chest Heart & Stroke Scotland
- Inform Scotland
- Professor Claudia Estcourt, Professor of Sexual Health and HIV at Glasgow Caledonian University and Honorary Consultant in NHS Greater Glasgow and Clyde
- Professor Phyo Kyaw Myint, Chair in Old Age Medicine (Clinical), University of Aberdeen
- The Health and Social Care Alliance Scotland (the ALLIANCE)
- Hospice UK
- Macmillan Cancer Support
- Marie Curie
- Dr Francisco Perez-Reche, Senior Lecturer, University of Aberdeen
- Public Health Scotland
- Royal College of Emergency Medicine
- Royal College of General Practitioners Scotland
- Royal College of Physicians of Edinburgh
- Scottish Centre for Administrative Data Research (SCADR)
- Scottish Intensive Care Society
- UK Medical Freedom Alliance
- Professor Sarah Wild, Professor of Epidemiology, University of Edinburgh

8. All the submissions can be read at the following link—

[Published responses for Excess deaths in Scotland since the start of the pandemic - Scottish Parliament - Citizen Space](#)

9. The Committee has received written submissions from the following organisations to inform this evidence session, which are provided in **Annexe A**—

- Royal College of Physicians of Edinburgh
- Royal College of Emergency Medicine
- Royal College of General Practitioners Scotland
- Scottish Intensive Care Society

10. As part of the inquiry, the Committee’s advisers suggesting sourcing information on excess deaths including key data and trends. This information has been provided by the Scottish Government and is attached at **Annexe B**.

## Next steps

11. The Committee will take further evidence on this inquiry at its meetings on 10 and 17 March 2022.

**Committee Clerks**  
**February 2022**

## **ANNEXE A**

### **Royal College of Physicians of Edinburgh's written submission**

#### **1. Has the public health emergency shifted from COVID-19 deaths to deaths from non-COVID-19 conditions?**

A. Published data in Scotland indicate that the difference in average deaths and current total deaths for the past 6 months is not accounted for by COVID deaths. It seems unlikely that deaths are occurring from COVID that are not detected and recorded as such. In light of this, our Fellows and Members suggest that deaths from other conditions may have increased.

B. Published data from the USA suggests that around one third of excess deaths may relate to non-COVID causes.

C. It is likely that the increase is accounted for by deaths due to factors such as cardiovascular disease, chronic respiratory disease, diabetes mellitus, dementia, and cancers.

D. The natural history of these conditions is such that a lag period may occur between progression and death. As such, the impact of COVID on excess mortality is likely to continue for a substantial period – even if COVID numbers were to dramatically decline now.

E. Both COVID mortality and the non-COVID conditions apparently causing increased mortality are highest in older people – countries like Scotland with ageing populations are likely therefore to see higher impacts in both categories.

F. In countries with high vaccination rates it appears likely that the direct effect of COVID on mortality will decline.

G. As such, our Fellows and Members indicate that the public health emergency has shifted to non-COVID conditions. However, COVID should continue to be regarded as a serious mortality threat.

#### **2. Is there evidence that patients are now presenting in a more acute condition?**

A. Anecdotally yes, but College Fellows and Members are not aware of any published data to support this.

#### **3. What accounts for the deaths from non-COVID-19 conditions?**

A. In general, affording primacy to the care of a single condition is likely to result in a decline in care of other conditions, particularly when that condition is new.

B. Several specific factors are likely to apply, including delayed or non-presentation (concern of burdening the NHS or being exposed to COVID); reduction in availability

of - - or access to investigative and treatment services due to COVID pressures for both acute and chronic disease; lifestyle change associated with “lockdown”; changes in mental health associated with the pandemic in general and specific societal consequences such as “lockdown”.

C. Some of these factors may have concurrently reduced deaths from other conditions, for example, accidental deaths associated with travel to work. Our Fellows and Members feel this is unlikely to offset the increase to any significant degree.

#### **4. Is there enough of a strategic focus on the indirect health impacts of the pandemic?**

A. The fact that this question is being asked by the Inquiry indicates recognition and acceptance of the issue.

B. The pressing and immediate nature of the pandemic, combined with the known workforce pressures that existed before the pandemic began, has meant that there was little choice in how workforce could be deployed to date.

C. A balance of risk between COVID care and care of non-COVID disease exists and has existed for some time. The direct risk from COVID may be currently declining, and the absolute and proportionate risk of indirect harm from non-COVID disease appears to be rising now. As such, non-COVID disease must be considered a core strategic focus for health and care policy, both now and long-term.

#### **5. What are the realistic options open to the government in addressing the indirect health impact of the virus in winter 2021/22?**

A. As above, workforce, and to a lesser extent facility constraint, means that capacity to tackle indirect health impact is limited.

B. At the time of writing this submission, the Omicron variant is placing extreme stress on the NHS, largely through its impact on staffing.

C. Simple messaging, as has been a theme throughout the pandemic, about seeking help for new or significant symptoms that might suggest heart disease, stroke, or cancer in particular should be emphasised.

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

E. This means reconsidering priorities for care and treatment of non-COVID disease.

## **The Royal College of Emergency Medicine's written submission**

For several years, the NHS has been under considerable strain, not least in recent times; the pandemic and its aftermath have added unique pressures to the health and social care system. Emergency Departments (EDs) are particularly well placed to analyse this strain, partly due to the nature of them being open and accessible 24/7 meaning patients turn to A&E when they feel they have nowhere else.

Furthermore, social determinants of health play a significant role in a patient's likelihood of attending an ED. The most deprived in society attend EDs twice as much as the least deprived – this is largely down to poorer provision of primary care in deprived areas. When other parts of the health and social care system are overstretched or not functioning as they should, the consequences tend to converge in the ED, resulting in emergency departments playing the role as the safety net for not only the patient, but the system.

### **Capacity**

However, EDs have become increasingly unequipped to deal with demand. Between 2015 and 2019 there was a loss of over 1000 acute available beds in NHS hospitals across Scotland despite consistently reaching bed occupancy rates of higher than the recommended limit of 85% in the same time frame. Moreover, we know that further beds have been taken out of the system during the pandemic to allow hospital to comply with Infection Prevention and Control measures. Importantly, bed numbers prior to the pandemic should not be seen as the standard that we need to return to, as bed occupancy levels were higher than what is deemed safe and putting strain on hospitals, which in turn can decrease the quality of care that patients receive.

High levels of bed occupancy are an important indication that the health system is under pressure. Maintaining bed occupancy rates of 85% ensures that there's additional capacity in the system to meet surges in demand and to enable patients to receive the care they need in a timely manner. For acute beds, safe levels have not been met since 2013. Insufficient bed availability can lead to increased waiting times for patients, crowding and consequently corridor care in EDs, and it can increase the rate of hospital-acquired infections, which has become even more dangerous due to the pandemic.

High bed occupancy rates are part of a large domino effect that is indicative of a system under pressure. When bed occupancy levels are high it becomes extremely difficult to admit patients in a timely manner. Most EDs have been stretched beyond the capacity for which they were designed and resourced to manage at any one time. As a result of this, long delays, crowding and corridor care have become commonplace in our EDs. In 2021 alone, there were 12,888 12-hour delays, more than in 2018, 2019, and 2020 combined. Long waits tend to occur when there is poor patient flow in a department and high rates of exit block. On average 1,300 beds a day were occupied with a patient experiencing a delay to their discharge.

This can happen when patients who are medically fit to leave are unable to be discharged as they require help to recover in the form of a social care package, which may not be immediately available. This results in their hospital bed being unavailable to the next patient, causing further Emergency Department crowding. On average, 75% of delayed discharges are down the health and social care reasons. Care should be provided in the community where possible. Health Boards and Local Authorities, working with the third sector and independent providers, should adopt a 'home first' approach to enable more people, who have attended an Emergency Department or have been admitted to hospital, to be assessed and recover in their own homes to avoid unnecessary long stays in hospital beds. This will be achieved through delivery of four 'discharge to recover and assess' active therapeutic pathways, embedded locally.

Furthermore, the effects of crowding and poor patient flow trickle out beyond the ED. When bed occupancy is high, ambulances arriving to the department with patients who are ready to be admitted are then required to wait and care for the patient in the ambulance until a bed becomes available. This creates what is known as ambulance stacking. With ambulances tied up outside the ED, they are then not able to respond to calls from the community and this can have devastating consequences. We are seeing worrying rates of ambulance delays in Scotland with sometimes devastating consequences.

## **Excess Deaths**

The effects of under-staffed and under-resourced EDs should not be underestimated. We have known for some time that these system pressures cause harm to patients, however it has been impossible to quantify until now. A recent study published by [Getting it Right First Time](#) explored the relationship between delays to timely admission and patient harm and at what point any harm started. While the data was supplied by EDs in England, a logistic regression model was used that accounted for all confounding variables including:

- age and gender;
- deprivation;
- Elixhauser comorbidity index;
- month / year / hour of day;
- number of emergency admissions in the previous 12 months;
- number of ED attendances in the previous 12 months;
- trust / site;
- and ED crowding (as measured by performance against the NHS four-hour operational standard)

As such, it is extremely likely that the findings of this study are applicable to the Scottish context as the healthcare pathways and population needs are largely comparable.

**Table 30: ED delay-related mortality**

Hours in the ED	SMR	Percentage change in the SMR	95% lower confidence limit for the SMR	95% upper confidence limit for the SMR	Adjusted absolute mortality rate	Number needed to harm (30-day mortality)
Up to 4 hours	0.94	-6%	0.92	0.95	8.5%	-175
4 - 6 hours	1.06	6%	1.04	1.08	9.5%	192
6 - 8 hours	1.14	14%	1.11	1.18	10.3%	77
8 - 12 hours	1.16	16%	1.12	1.21	10.4%	67

Data source: HES and ONS 2016 - 2018<sup>28</sup>

The report shows that an increase in Standardised Mortality Ratio is associated with ED delays beyond 5-6 hours from time of arrival. Their logistic regression model found that of those patients delayed by 8-12 hours in the ED, there was an associated 30-day mortality rate of 1 in every 67 patients. To put this into perspective, this is equal to over 500 excess deaths in 2021 in Scotland, entirely attributable to the delay to admission these patients experienced. There are numerous clinically plausible reasons to support the hypothesis of a temporal relationship between delayed admission and increased mortality, with ample published evidence of the harmful effects of delays to therapy, multiple handovers and increased length of hospital stay. The quantitative effects on morbidity and the qualitative effects on patient experience are known to be even greater. We must curb this trend now and it will require prioritising patient flow. This means bolstering social care, expanding capacity in EDs including bed stock and ensuring there is sufficient workforce to safely staff departments.

## Staff

Emergency Departments represent one of the most intense working environments in the NHS. Over the years, increasing demand and high bed occupancy has led to frequent occurrences of exit block. This results in crowded departments which have become all too common. The demanding nature of this setting is a regular cause of staff dissatisfaction, attrition, and career burnout. Furthermore, the pandemic has exacerbated many of these challenges – there is now an urgent obligation to plan for the future healthcare needs of Scotland.

When coronavirus struck Scotland, Emergency Medicine staff were already operating in understaffed and under-resourced departments. As illustrated in Table 1 below, the number of attendances is increasing every year, yet the physical size of hospitals has not increased accordingly. This intense working environment puts a huge amount of strain on staff which can result in attrition from the specialty.

Additionally, ED workforce models are predicated on insufficient numbers of trained Emergency Medicine clinicians, who are expected to deliver safe care whilst quality assuring the actions of staff in training. Trainee staff form the majority of any ED workforce numerically and are expected to be delivering quality assured care in the same episode. Added to this is the churn of learners through EDs and increasing the service delivery, supervision and teaching responsibilities on the existing number of trained clinicians.



RCEM recommends that the safe staffing of EDs should be based around a ratio of one Whole Time Equivalent (WTE) consultant per 4000 annual attendances. Table 1 below shows that despite the number of Emergency Medicine (EM) consultants increasing at a constant rate every year, the expansion in numbers is still not happening fast enough to cope with the level of demand. This results in continued understaffing in departments. At present there is a shortfall of roughly **130 consultants** in Scotland. As [evidence shows](#), understaffing means the EM workforce consistently reports the highest levels of work intensity of all the medical specialties, leading to high rates of attrition from both training and the specialty, only further exacerbating the issue.

**Table 1. Ratio of consultants to annual attendances**

Year	Average number of WTE consultants	Attendances at Type 1 EDs	Attendances per consultant
2016/17	215	1,329,488	6,183
2017/18	222	1,352,331	6,091
2018/19	228.5	1,393,238	6,097
2019/20	236.5	1,398,441	5,913

The attendance and consultant numbers cannot be untangled from the effect they have on patient care. In a recent RCEM membership survey, **73%** of respondents indicated that workforce pressures in their EDs had an impact on patient safety even before the pandemic.<sup>1</sup> We asked the **16%** of respondents who selected that patient safety had not been impacted by workforce pressures and a third of those expressed that it was purely down to the discretionary efforts of staff. This not only confirms that the workforce crisis facing the specialty existed before the pandemic but also demonstrates how crucial safe staffing is in EDs. It is important to note that consultant numbers alone do not reveal the full picture. Senior decision-makers are an integral part of ensuring EDs are staffed safely. This group is made up of consultants, as well as a non-consultant group comprising of Higher Specialist Trainees, Associate Specialists, and Specialty Doctors. EM workforce planning has been traditionally modelled on forecasting only the number of consultants needed in six years' time (the training cycle) and therefore how many training places are required *now* to produce this number. What this method fails to acknowledge is the crucial role that non-consultant senior decision-makers play.

To better understand the nature of these challenges on our staff, the Royal College of Emergency Medicine carried out the [Scottish Workforce Census](#) on behalf of the National Board for Scotland. This census is the first of its kind for the College and it seeks to understand staffing numbers and the true extent of the workforce pressures present in emergency departments across the country. We asked all major departments to share their ideal staffing numbers for each staff group by the year 2026 – table 2 displays the results.

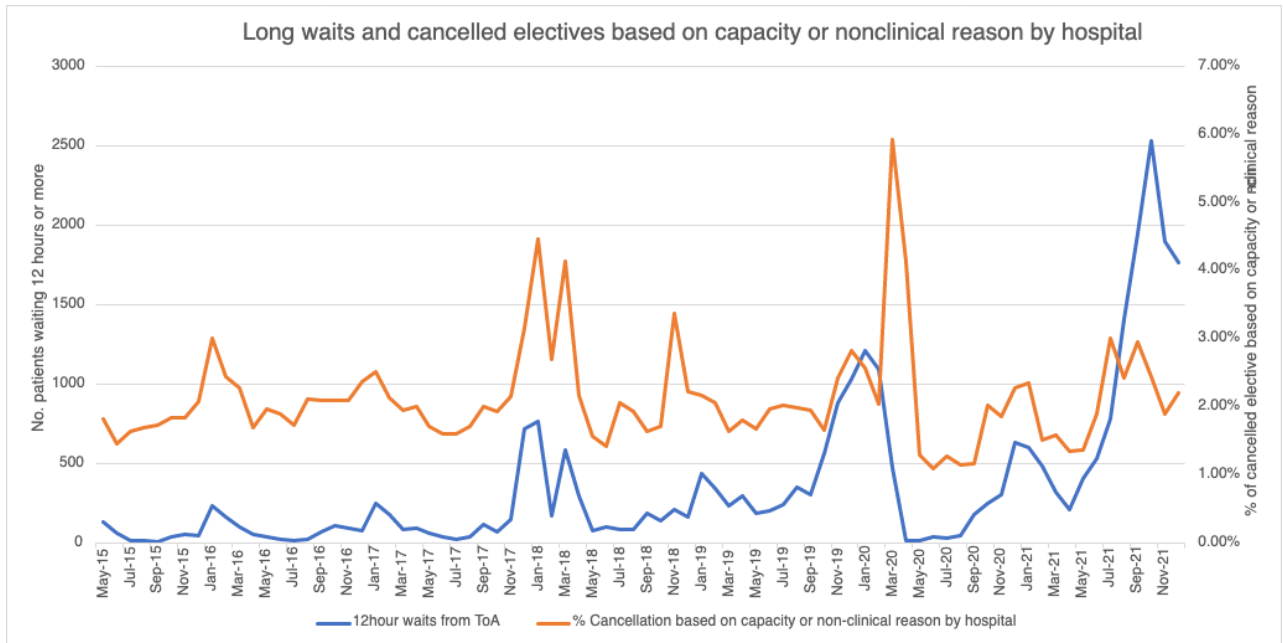
**Table 2. Ideal Staffing by 2026**

Staff Group	Ideal Total by 2026	Increase from current
Consultant	365	113
Higher Specialist Trainee/Non-Consultant Senior Decision Maker	227	74
Junior Doctor (Non-senior decision maker grade)	340	180
ACP/ANP/PA	120	38
ENP	172	-10

While the results in table 2 show that the aspirational increase in non-consultant senior decision-makers is not as sizeable as the consultant group, it represents a more complex issue. This is because there is often no predictable or straightforward career pathway for becoming a non-consultant senior decision maker. As a result, it is difficult to estimate where these staff members will come from despite the fact, they are an essential component of any well-run department. Furthermore, this is a role regularly being covered by locums, and in many cases, by consultant locums covering a more junior gap due to a real lack of suitable individuals to fill these roles. This must all be accounted for in workforce planning and any planned expansion of training places.

**Impact of Covid**

When EDs experience a surge in demand and are unable to admit patients in a timely manner due to a lack of available beds, it is not uncommon for this to disrupt elective care. As we have seen most acutely during the pandemic, when there is a surge in urgent care and extra capacity is required, elective care is put on hold. The graph below shows 12-hour waits in EDs since records began alongside the percentage of cancelled electives based on capacity for non-clinical reasons by the hospital. Interestingly, putting these two data points side by side demonstrates the clear impact that lack of capacity has on both parts of the system and how they cannot be tackled in isolation. When there is a spike in long waits in the EDs, there is also a sharp increase in the percentage of elective operations cancelled for capacity or non-clinical reasons.



Furthermore, EDs impacted by the elective backlog as patients may present with complications from delayed or cancelled procedures. We do not underestimate the scale of the challenge ahead in terms of tackling the elective backlog however, this issue cannot be considered in isolation. Analysis conducted by the King’s Fund found that waiting lists for routine treatments have grown by 50% in the most deprived parts of England, compared with nearly 35% in the most affluent areas. Additionally, those in deprived areas were nearly twice as likely as those in the wealthiest to wait more than a year for treatment – it is likely we will see the impact of this in EDs. It is crucial that Unscheduled Care is firmly embedded into any plans so that inevitable future surges in demand do not derail elective care once again and jeopardise efforts to restart our NHS.

## Conclusion

There is a tendency for policymakers to favour short term solutions and quick wins. This approach will have catastrophic consequences for the health service if not paired with long term interventions. There has been a heavy focus on demand management with the aim of redirecting patients away from the ED, such as the NHS24 initiative. While this can be helpful it is only one small part of the solution as it assumes that the low acuity patient is the beginning and the end of the issue. It also requires alternative services to be available, which is often not the case. Lasting improvement will require an increase in capacity, namely beds, expanding the physical size of departments and the workforce in the long term to support the consistent increase in demand from all types of patients that is unlikely to cease. Patients will continue to come to avoidable harm and even death unless system pressures are addressed.

## **Royal College of General Practitioners Scotland's written submission**

On behalf of the Royal College of General Practitioners Scotland (RCGP Scotland), I am writing in response to the COVID-19 Recovery Committee's inquiry into excess deaths in Scotland since the start of the pandemic.

GPs and practice teams have played a pivotal role in the COVID-19 pandemic response. Practices have remained open to continue to provide care to patients, and GPs have also maintained out of hours working. GPs and their teams have played a key role in staffing the COVID pathways and vaccinating their most vulnerable patients. Following the first lockdown, practices also resumed cervical screening as directed by Scottish Government. To ensure that GP practices could continue to provide safe and effective care during the pandemic, GPs and their teams rapidly altered the way in which they delivered care by embracing new technologies – such as video, telephone and e-consultations– in the early stages of the pandemic. This allowed non-COVID care to be provided throughout the pandemic, while also ensuring that practices could remain open for patients where it was clinically indicated they should be seen face to face.

GPs and their practice teams also provided important assistance to their most vulnerable patients during critical stages of the pandemic. During the first lockdown, practices contacted their patients who were identified for shielding: this was a crucial public health intervention, alerting patients to the risks and increasing their understanding of why they were being asked to shield. These conversations also often provided an opportunity to review how patients were provided with support and given health educational advice more generally.

These interventions will have significantly reduced the likely number of excess deaths both directly and indirectly caused by COVID-19.

Throughout the pandemic, GPs and their teams have operationalised national guidance to ensure that practices remain safe and COVID secure in so far as is possible. Updates to this guidance have allowed GPs and their teams to see an increasing number of patients in person over time where this has been practically possible within practices.

We note that the accompanying data from the Scottish Government cited within the call for views lists “people avoiding contacting GPs” as an indirect health impact of the COVID-19 pandemic. We are deeply concerned that 25% of respondents agreed they would avoid contacting a GP practice at the moment for immediate non-COVID19 health concerns.

At RCGP Scotland, we have been working throughout the pandemic to promote the message that general practice is open – including through contributing to Scottish Government national public messaging campaigns; at an earlier stage in the pandemic, our former Chair Dr Carey Lunan was the face of a televised Scottish Government advert urging the public to continue to present to general practice if they had medical concerns.

While data on general practice workload is generally poor in Scotland, anecdotally there was an initial decrease in patient contacts in the very early stages of the pandemic as the public responded to strict lockdown messages. However, this trend quickly reversed and our members are now reporting significantly increased workload in comparison to previous years. This is particularly notable with regards to mental health consultations which have increased considerably since the beginning of the pandemic. In a survey of RCGP Scotland members, carried out in February 2021, 94% of GP respondents reported that the number of patients presenting with mental health and wellbeing concerns had increased since the COVID-19 pandemic began<sup>1</sup>. GP data from England has shown marked increases in the number of consultations being carried out. While we cannot comment definitively, we have no reason to believe that comparative data from Scotland would be much different.

The Committee has asked whether there is evidence that patients are now presenting in a more acute condition. The term “more acute condition” can be interpreted in several ways, however anecdotal feedback from our members suggests that GPs are seeing patients presenting later in the course of an illness, including cancer. Some patients are presenting with severe acute illness which requires immediate hospital admission. It is difficult to compare these experiences reliably with the pre-COVID period without the appropriate data.

The COVID-19 pandemic has highlighted the interconnected nature of our health service; it is clear that when one part of our health service is under extreme pressure, this has an impact on other parts of the system. This can have a direct impact on patient care and the ability for the health service to cope with additional demands.

When considering the options available to the Government in addressing the indirect health impact of the virus in winter 2021/22, we cannot overlook the ongoing threat posed by the Omicron variant. While we await key data on many aspects of the new variant, it is clear that it presents a significant challenge to the health and social care workforce, which is already operating at diminished capacity in many areas.

In terms of general practice, we believe that the following options should be considered to help address the indirect health impact of the virus this winter:

- To increase the support and care that GPs and their teams can provide for those patients, mental health clinicians should be made available to all GP practices across Scotland. Feedback from practices which already have mental health clinicians in post has been overwhelmingly positive, with patients receiving a high standard of mental health care and GPs being able to see more patients with these and other healthcare needs.
- To improve the interface working between primary and secondary care, we would like to see funded interface groups rolled out to every health board in Scotland. Improving interface working brings significant benefits for patient

---

<sup>1</sup> RCGP Scotland survey in field February 2021. Total number of GP responses – 157.

care, particularly in instances where a patient's care crosses over many different parts of the healthcare system.

- Delivering robust public messaging on appropriate use of NHS services must remain a priority for the Scottish Government over the coming months. Ensuring that patients understand when it is necessary to seek medical attention is key to addressing indirect health impacts of the virus. With health services stretched to their limits in many areas due to the effects of the Omicron variant, ensuring that patients have the tools to effectively manage their own health conditions (when this is appropriate) and which service is most appropriate for their care needs, will help to ensure that NHS services are available for those patients who require them over this difficult period.
- We await with interest the publication of the Scottish Government's health and social care workforce plan. We view credible workforce planning, which is underpinned by accurate data and based on Whole Time Equivalent (WTE) numbers, to be crucial to the future stability of the workforce. Ensuring that the workforce is available to treat and care for patients must be a major priority for the Government when considering how to address the impact of the virus on patients' health.
- We remain extremely concerned about the wellbeing of the general practice workforce. Ensuring that measures are put in place to enhance wellbeing and reduce burnout must be a priority for the Scottish Government. We welcome the introduction of the Workforce Specialist Service in Scotland, which provides mental health and wellbeing support and advice to the health and social care workforce. We believe additional measures, such as protected learning time in the working week of GPs and their teams, should now be implemented across all Health Boards to enhance wellbeing, learning and development.

We acknowledge that we have not answered each of the questions posed by the Committee. However, we would be happy to expand on any of the above areas or provide additional information on the role of general practice throughout the pandemic, should that be of help to the Committee's inquiry.

## **Scottish Intensive Care Society's written submission**

### **1. Has the public health emergency shifted from COVID-19 deaths to deaths from non-COVID-19 conditions?**

Not really, we have seen continued high rates of covid 19 deaths as well as from non covid conditions.

From an ICU perspective we have seen later presentations of patients with critical illness as a result of delays to surgical intervention resulting from the reduction in theatre activity as staff were redeployed to cover the pandemic.

For example, GI obstruction presenting as an emergency due to delayed diagnosis and elective surgical interventions for bowel cancer.

Abdominal aortic aneurysm rupture due to delay in elective AAA repairs

We have also seen an apparent increase in the number of patients presenting to ICU with self-poisoning/self-harm/ attempted suicide. Possibly related to the mental health effects on the general population during the pandemic. Such as isolation/loss of normal socialisation etc.

Important for the committee to note that it is the same groups of staff (predominantly anaesthesia and intensive care) who are doing both covid and non covid work.

### **2. Is there evidence that patients are now presenting in a more acute condition?**

Yes, please see above examples

### **3. What accounts for the deaths from non-COVID-19 conditions?**

Delayed presentation plus general increase in "deconditioning" within the population possibly multifactorial or due to decreased opportunities for exercise during lock down

### **4. Is there enough of a strategic focus on the indirect health impacts of the pandemic?**

Not really but the reality of this is all about the limitations of our staffing.

We can pivot from normal service to becoming a covid NHS but we can't do both. Staff are exhausted and burnt out after 2 years of repeated waves of the pandemic and many are leaving the NHS. Replacement staff often do not have the knowledge, skills or experience to be able to provide safe patient care.

We need to seriously focus on retaining experienced staff who are working in business critical services through enhanced T&C's as well as reducing the incentives for senior staff to leave the NHS via poorly thought through pension changes.

Exploration of cold (elective centres) and acute hospitals doesn't really work given Scotland's geography and when a critical care bed is required it is the same staff providing both services.

Infection prevention control measures, cohorting of patients based on illness and isolation have further reduced both the "efficiency and productivity" of providing healthcare for the critically ill.

#### **5. What are the realistic options open to the government in addressing the indirect health impact of the virus in winter 2021/22?**

From an ICU perspective there are few realistic options to address this over the coming winter of 21/22.

Staffing, infrastructure and bed numbers all need to be urgently addressed. The health service budget is finite and was under resourced given the demands even before the pandemic.

Workforce modelling within ICU shows many senior staff are in their 50's and are now actively considering leaving the NHS. Recruitment (even if possible) will not address this developing "gap".



## **ANNEXE B**

### **Letter from the Cabinet Secretary for Health and Social Care to the Convener - 14 February 2022**

#### **Inquiry into excess deaths in Scotland**

I am writing further to your request, on 17 January 2022, to provide information to support your inquiry into excess deaths in Scotland since the start of the COVID-19 pandemic.

The Scottish Government is pleased to assist with the Committee's inquiry, and has provided responses to the each of the information requests in the annex below.

The Committee's request for information covered a range of different policy areas and data sets. Some of the information requested is already in the public domain, where this is the case we have excerpted the relevant material and signposted the source. Unfortunately it was not possible to provide all of the information requested, where we were unable to precisely meet a request we have added a note to explain this and noted if this is due to be published in the coming months.

Please do not hesitate to reach out if you have any further questions or requests, my officials and I shall be happy to assist.

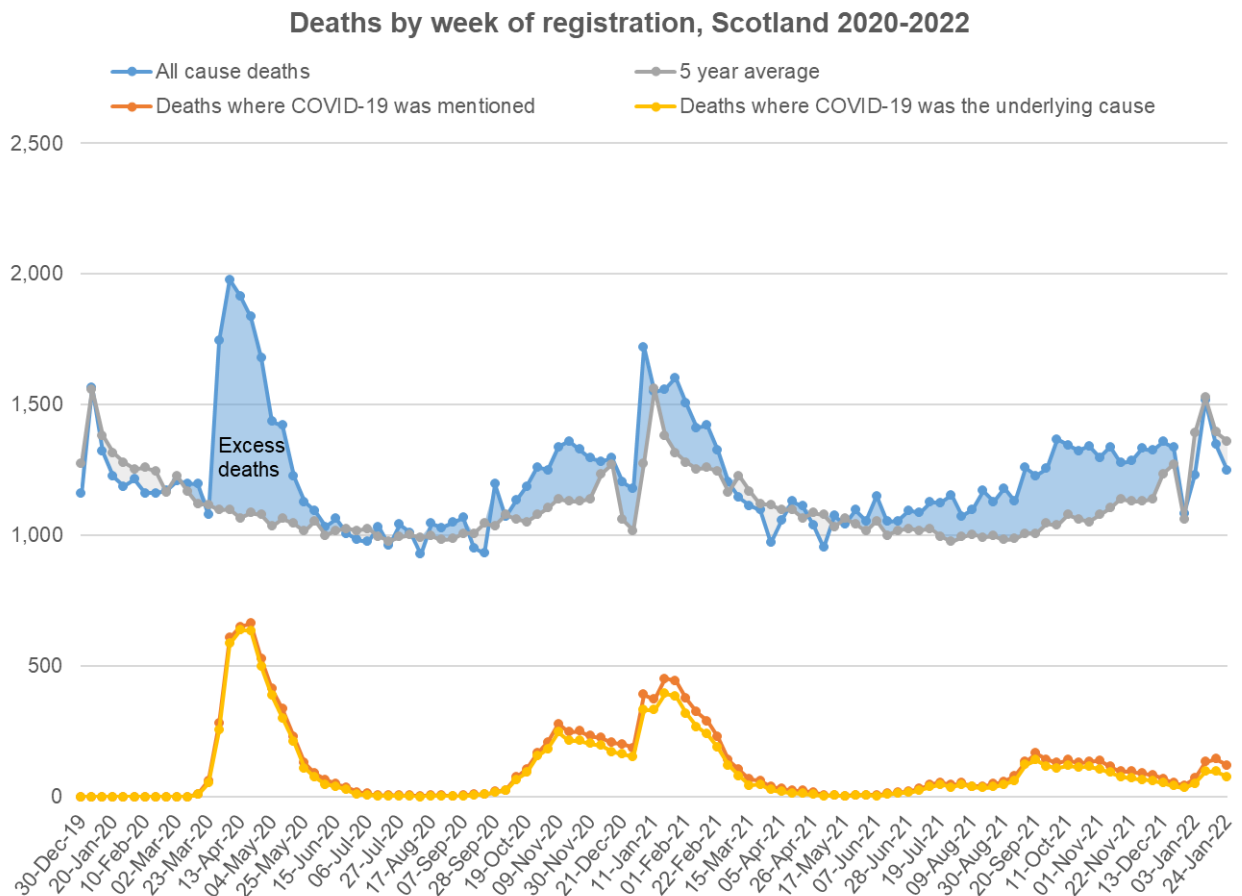
Kind regards,

**HUMZA YOUSAF**

## Annex: Scottish Government responses to information requests from the COVID-19 Recovery Committee

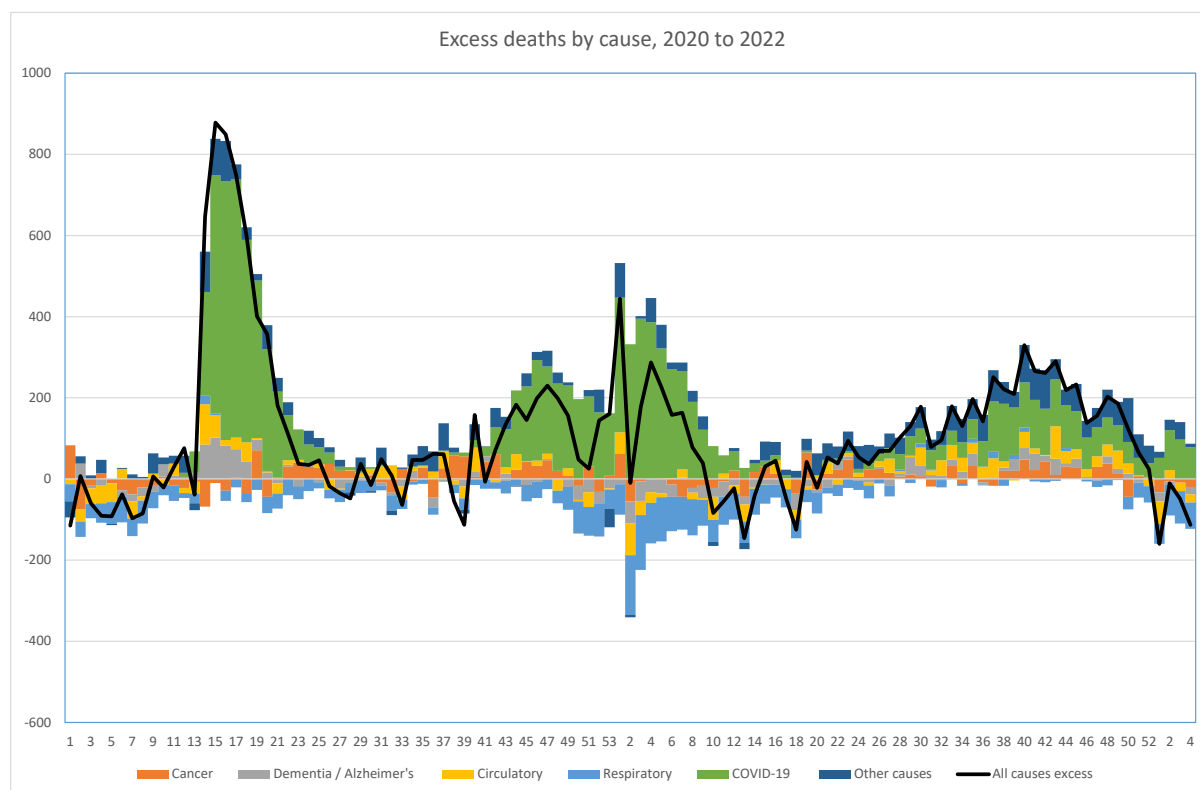
1. A combined chart of excess deaths broken down by each week and weekly COVID deaths (as seen on the four harms data on SG website).
2. The difference between the two lines is important as these are the unexplained deaths – the Committee want to know their causes, and whether there is a focus of cause

National Records of Scotland (NRS) publish data on deaths involving COVID-19 in Scotland on a weekly basis. The chart below shows the excess deaths and total deaths by week for Scotland from the week ending 30 December 2019 – the week ending 30 January 2022.



Source: <https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-22-data-week-04.xlsx>

Excess deaths compared to the 2015-2019 average for four main underlying causes of death (cancer, dementia, Alzheimer’s disease, circulatory causes and respiratory causes) for 2020-2022 are shown in the chart below.



Source: <https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-22-data-week-04.xlsx>

In the first wave the majority of excess deaths involved COVID-19 but there were a small number involving other causes, including dementia, Alzheimer’s, circulatory causes. Later in 2020 excess deaths were lower than COVID-19 deaths, mainly due to a reduced level of respiratory deaths compared to the expected level. This continued for the early part of 2021, and from late spring onwards, there were excess deaths across most of the causes (except respiratory).

Details on excess deaths by underlying causes of death for 2019, 2020 and 2021 are publicly available<sup>2</sup>. Detailed cause of death figures for 2021 are not yet available, the Scottish Government intends to publish these by summer 2022, and we will of course be happy to notify the Committee when these have are published. Monthly data on deaths registered in Scotland is publicly available<sup>3</sup>. Secondary analysis of NRS deaths data relating to people with dementia during the COVID-19 pandemic in different settings was published on 9 February 2022<sup>4</sup> and a letter outlining the key findings has been shared with you.

<sup>2</sup> <https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-22-data-week-04.xlsx>

<sup>3</sup> [Monthly Data on Births and Deaths Registered in Scotland \(Table 5\)](#)

<sup>4</sup> <https://www.gov.scot/isbn/9781802018905>

**3. Evidence of delayed presentation of disease (e.g. stage of cancer presentation – possible source SMR6 cancer registry data.**

Cancer diagnosis and treatment have remained a priority throughout the pandemic and patients referred with an urgent suspicion of cancer have continued to be prioritised for key diagnostic tests.

The most recently published information, from Public Health Scotland, covers staging information for Lung, Breast and Colorectal cancers only (up to December 2020) and is publicly available<sup>5</sup>.

Staging is only one aspect of measuring overall cancer care in Scotland, where we still continue to meet our 31 day treatment standard. During the COVID pandemic, once a decision to treat was made, cancer patients in Scotland waited on average between two to five days for treatment. We have treated more patients within the 62 day standard during the latest published quarter (Q3 2021) (3,334) compared to the same time pre-Covid (Q3 2019, 3,263).

The Scottish Government's commitment to improving cancer diagnosis and treatment is reflected in our £44m Detect Cancer Early Programme, which we have committed an additional £20m to over the parliamentary term. The Scottish Government has established three Early Cancer Diagnostic Centres (ECDC), providing primary care with a new referral route for patients with non-specific symptoms suspicious of cancer. We also recently invested £10m to support cancer waiting times improvements, helping ensure those with a suspicion of cancer are seen and treated as early as possible.

**4. Information on severe cardiac disease. How many people are dying whilst on waiting lists for intervention? What is happening to the rate of sudden cardiac death in the community?**

NHS Scotland does not currently collect data on whether the cause of death for a person who is removed from elective waiting lists as a result of dying is related to the condition that necessitated them being on the waiting list.

As noted above, detailed breakdown of excess deaths by cause, including sudden cardiac deaths, is available for 2020, although detailed cause of death figures for 2021 are not yet available. These are due to be published in summer 2022. The Scottish Government will be happy to notify the Committee once these are published.

**5. Information on diabetes - evidence of more frequent presentation of failures of control i.e. A/E attendances and admissions for hypoglycaemic episodes or episodes of diabetic ketoacidosis**

<sup>5</sup> [Cancer staging data using 2018 to 2020 DCE data - the impact of COVID-19 - Cancer staging data using 2018 to 2020 DCE data - the impact of COVID-19 - Publications - Public Health Scotland](#)

Data provided by Public Health Scotland details annual trends on continuous inpatient stays by diagnosis and shows that there has been a reduction in admissions with diagnosis diabetes in 2020/21 compared to 2019/20 as shown in this publicly available analysis<sup>6</sup>.

**6. Information on A/E attendances for acute asthmatic attacks and admissions for that and also for chronic obstructive airways disease**

As noted above, data provided by Public Health Scotland details annual trends on continuous inpatient stays by diagnosis<sup>7</sup>. This includes some information on hospital admissions with asthma and Chronic Obstructive Pulmonary Disease (COPD) diagnoses and combines elective and emergency admissions. There has been a reduction in admissions with a diagnosis of disease of the respiratory system in 2020/21 compared to 2019/20.

**7. Waiting times data, ideally the Committee is looking for data on when someone who is presenting now will realistically be treated, i.e. how long will they wait given what we know about current service levels.**

**8. Information on waits for “urgent suspicion of cancer” cases**

Public Health Scotland publishes a wide range of information on waiting times, which is available from their website<sup>8</sup>.

We recognise the significant pressure that the NHS continues to experience and we cannot underestimate the risks from COVID-19, which is likely to remain with us for some time to come. Evidence based caution is at the forefront of our decision making and we will continue to work with Health Boards to remobilise the NHS in the safest possible way, while also supporting Boards to prioritise elective activity on the basis of clinical urgency.

Public Health Scotland are developing a new set of statistics in the topic area of ‘urgent suspicion of cancer’ and we will be happy to share this publication with the Committee as soon as the data is released

**9. Information on endoscopy and cystoscopy waiting times and those for CAT and PET scans**

Public Health Scotland publish data on waiting times for key diagnostic tests including endoscopy and cystoscopy and CAT scans<sup>9</sup>.

<sup>6</sup> [Acute hospital activity and NHS beds information \(annual\) - Annual - year ending 31 March 2021 - Acute hospital activity and NHS beds information \(annual\) - Publications - Public Health Scotland](#)

<sup>7</sup> Ibid

<sup>8</sup> [Diagnostic waiting times - Waits for key diagnostic tests 30 November 2021 - NHS waiting times - diagnostics - Publications - Public Health Scotland.](#)

<sup>9</sup> <https://publichealthscotland.scot/media/10505/2021-11-30-diagnostic-tests-nov21.xlsx>

The Scottish Government has committed to a Endoscopy and Urology Diagnostic Recovery and Renewal Plan, backed by total investment of £70 million over the lifetime of the Plan.

#### **10. Information on routine screening programmes e.g. breast, cervix, bowel and others during the pandemic**

All NHS Scotland national adult screening programmes have resumed safely having been paused in the early stages of the pandemic. This has been taken forward in a series of stages, with the initial focus on higher-risk screening participants.

The Scottish Breast Screening Programme (SBSP) restarted in August 2020 in line with the recommendations of the organisations that oversee screening in Scotland, including the Breast Screening Programme Board and the Scottish Screening Committee. However, these organisations and the National Screening Oversight (NSO) have recommended a continued pause to self-referrals for women aged 71 and over, to allow the service to prioritise those aged 50 to 70 for whom the benefits of screening are clear. The SBSP continues to recover although capacity challenges remain. Prior to omicron, 70% of all women were receiving appointments within 41 months of their last screen. Breast screening for those at very high risk of cancer (which is not a nationally managed screening programme) and annual surveillance scans for those treated for breast cancer were not affected by the pause to the national screening programme.

Non-routine cervical screening appointments resumed in mid-July 2020, with a catch-up exercise undertaken which prioritised higher-risk participants on the non-routine pathway. Those receiving non-routine screening are now receiving appointments as if the pause had not happened. Routine screening appointments commenced from September 2020. Currently, participants on the routine pathway are receiving their invitations around six months later than they would have done pre-March 2020.

NHS Boards resumed bowel screening in October 2020, with new home testing kits for the bowel screening programme posted out from 12 October 2020. Bowel screening is continuing to operate in line with pre-COVID performance; the same number of invitations are being issued. In general, invitations are delayed by around six months for everyone on the programme. The exceptions are invitations for first screenings, which issue to participants as they turn 50 and become eligible for the programme. Uptake is slightly higher and positivity rate is consistent with that before the pause. Downstream colonoscopy capacity continues to be challenging, and the screening programme is monitoring the impact on the screening programme and exploring management options.

Abdominal Aortic Aneurysm screening resumed in July 2020, prioritising men in the high risk cohort. By the end of March 2021, annual statistics published by Public Health Scotland reported that the programme continues to send out the initial screening invitation at a 90.5% rate, which is lower to pre-Covid level of 97.4%, but above the KPI standard of 90%. However, the programme has maintained screening the eligible population before they turn 66 and 3 months at a rate above 75%. Which is similar to pre-Covid-19 rates.

Unlike the rest of the adult population screening programmes, the DES programme targets screening individuals with the specific condition of diabetes. The Diabetic Eye Screening Programme resumed in August 2020, prioritising those at high risk of developing diabetic retinopathy. Routine screening resumed in October 2020 once the programme had screened high risk screening participants. Despite the challenges, the programme continues to make steady recovery that is in line with the screening programmes recovery route map.

#### **11. Information on ambulance attendance time figures for each category of urgency, again shown over time if possible**

The Scottish Ambulance Service, as emergency front line responders, have played a pivotal role in the response to Covid-19. Despite significant workforce challenges, increased higher acuity demand and significant delays in handing over patients at emergency departments due to reduced capacity, the Service has been able to maintain a stable response to their highest risk patients.

The Scottish Ambulance Service have been publishing Unscheduled Care Operational Statistics publication since 24 November 2021<sup>10</sup>.

The Scottish Government acknowledged the additional pressures faced by the Service and introduced a package additional £20m investment in September 2021 to help increase capacity, support improved response times and support staff welfare. Work continues with the ambulance service and Health Boards to look at introducing further measures to help improve turnaround times at emergency departments for ambulances which will ultimately improve ambulance response times.

#### **12. Information on primary vs secondary cause of death (for example, attribution of cause, e.g. underlying mental health)**

The guidance for certifying doctors on completing death certificates suggests that they should be recording COVID-19 on the death certificate if the disease has played a role, but the guidance does not suggest that COVID should be recorded as a societal situation.<sup>11</sup>

Whether they record it as the underlying cause or as a contributory factor is dependent on the circumstances of each case and the chain of events which led to the death, the relevant guidance outlining this is publicly available<sup>12</sup>.

#### **13. Information on violent deaths, e.g. intimate partner violence**

<sup>10</sup> <https://www.scottishambulance.com/publications/unscheduled-care-operational-statistics/>

<sup>11</sup> [Death Certificates and Coding the Causes of Death | National Records of Scotland \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/death-certificates-and-coding-the-causes-of-death)

<sup>12</sup> [The Medical Certificate of the Cause of Death | National Records of Scotland \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/the-medical-certificate-of-the-cause-of-death)

The Homicide in Scotland 2020-21 National Statistics include all cases of Murder and Culpable homicide (common law) recorded by the Police in Scotland, this associated data is publicly available<sup>13</sup>.

Between 2019-20 and 2020-21, the number of homicide cases recorded by the police in Scotland decreased 15% (or 10 cases) from 65 to 55. This is the lowest number of recorded homicide cases since comparable records began in 1976. The nationwide lockdowns and other measures put in place to limit social contact during the pandemic may have had an impact on the number of homicide cases.

#### **14. Measures of background health of population, e.g. obesity**

In order to ensure that the effects of the pandemic on general population health have been understood the Scottish Government has taken steps to ensure that relevant measurements have been maintained throughout the pandemic. This includes the Scottish Health Survey being moved to a telephone basis after face to face interviews were stopped.

The latest Scottish Health Survey results can be found in full on the Scottish Government website<sup>14</sup>.

#### **15. Provision of preventative care and uptake of such measures**

In addition to the preventative measures provided by routine screening programmes, as detailed in Section 10, the Scottish Government is fully committed to tackling issues such as smoking, poor diet and levels of excess weight<sup>15</sup>, physical inactivity and alcohol misuse – all of which will support people to live longer, healthier lives. Work is underway to deliver a range of measures to target these harmful health behaviours early and provide access to person-centred treatment when needed.

Our 2021-22 Programme for Government<sup>16</sup> committed to introduce a Public Health Bill that includes restrictions on unhealthier food and drink promotions during the course of this Parliament. We continue to support boards to implement the 2018 A Healthier Future: type 2 Diabetes prevention, early detection and intervention: framework<sup>17</sup>. Boards provided weight management and type 2 diabetes services using remote support for patients during the pandemic. In 2021/22, we provided core funding of £5.7m to boards to improve weight management services, supporting adults with, or at risk of, type 2 diabetes or pre-diabetes. We also continue to fund the Healthy Living Programme in over 2,300 convenience stores, mainly in more deprived areas. The Scottish Government are also working with sportscotland to ensure that Active Schools programmes are free for all children and young people, providing more opportunities before, during and after school.

<sup>13</sup> [Homicide in Scotland 2020-2021: statistics - gov.scot \(www.gov.scot\)](https://www.gov.scot/statistics/homicide-in-scotland-2020-21)

<sup>14</sup> [Scottish Health Survey – telephone survey – August/September 2020: main report, published January 2021.](https://www.gov.scot/publications/scottish-health-survey-telephone-survey-august-september-2020-main-report/published-january-2021/)

<sup>15</sup> [A healthier future: Scotland's diet and healthy weight delivery plan - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/a-healthier-future-scotland-s-diet-and-healthy-weight-delivery-plan/published-july-2021/)

<sup>16</sup> [A Fairer, Greener Scotland: Programme for Government 2021-22 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/a-fairer-greener-scotland-programme-for-government-2021-22/published-july-2021/)

<sup>17</sup> [A Healthier Future: type 2 Diabetes prevention, early detection and intervention: framework - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/a-healthier-future-type-2-diabetes-prevention-early-detection-and-intervention-framework/published-july-2018/)



We provide £9 million a year to health boards to fund smoking cessation services in the most deprived areas. Smoking is a significant cause and effect of Scotland's unfair and unjust health inequalities, with smoking rates ranging from 35% in Scotland's most deprived communities to 11% in its least deprived. Each year, tobacco use is associated with 108,000 smoking attributable hospital admissions and 9,332 smoking attributable deaths in Scotland - a fifth of all deaths.

The majority of quit attempts through NHS stop smoking services are by people in the most deprived communities where smoking rates are highest. Around 70% of quit attempts are made through community pharmacies - who provide this service on behalf of NHS Scotland - rather than direct through specialist stop smoking services. The Scottish Government have set a target to reduce smoking prevalence in Scotland to 5% by 2034 and Government launched a consultation to introduce regulations on the domestic advertising of e-cigarettes on 3 February 2022.

The Local Delivery Plan (LDP) Standard for drug and alcohol treatment waiting times expects that 90% of people receive access to appropriate drug and/ or alcohol treatment within three weeks of referral to support their recovery. Since 2008 we have invested over £1bn to tackle problem alcohol and drug use, this year we're spending £140.7m on alcohol and drug use. Increased investment from the national mission on tackling drug-related deaths is being used by Alcohol and Drug Partnerships across Scotland to support people facing problems because of both alcohol and drug use. We are exploring the evidence around Managed Alcohol Programmes and are contributing to the running of the model being piloted in Glasgow by Simon Community Scotland and its evaluation.

Through the emerging Care and Wellbeing portfolio we are working to Improve Healthy Life Expectancy and deliver fairer outcomes. The portfolio, which we intend to stand up in the Spring provides an opportunity for us to design a progressive health and social care reform package that provide greater coherence, sustainability and improved outcomes within the portfolio.

Our NHS and social care institutions have a core role to play in reducing health inequalities in Scotland. We are supporting health and social care providers to become anchor institutions as part of the roll out of Community Wealth Building. As 'anchors', our health and social care services will support their local community through their spending, investment, employment and use of physical assets

A Preventative and Proactive Care programme has been established as part of the Care and Wellbeing Portfolio to give focus to this area of work across a range of policy areas. This programme aims to enable people to proactively keep well and independent and in the most appropriate care setting for their needs if they enter the care system. A range of pathfinders are currently being developed to consider this in a variety of contexts, including deep end GP Practices, prisons, residential rehabilitation, local authority areas and support for frail elderly people. This work is in the early stages of development and the Scottish Government will share outcomes in due course.