OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 24 March 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 24 March 2020

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HEALTH AND SPORT COMMITTEE
8th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeane Freeman (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 24 March 2020

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Lewis Macdonald): Good morning, and welcome to the eighth meeting of the Health and Sport Committee in 2020. I ask everyone to ensure that their mobile phones are off or in silent mode and not to use mobile devices for photography or for recording proceedings.

The first item on our agenda is to decide whether to take agenda items 4 and 5 in private. Do members agree to do so?

Members *indicated agreement.*

Coronavirus Bill

09:00

The Convener: The next item on our agenda is to hear evidence from the Cabinet Secretary for Health and Sport on the legislative consent motion on the Coronavirus Bill. The LCM was lodged on Friday by the Cabinet Secretary for the Constitution, Europe and External Affairs, Michael Russell, with support from Jeane Freeman, who is with us this morning.

Members will be aware that the Coronavirus Bill is a United Kingdom Government bill that has been proceeding at Westminster. The Scottish Parliament is due to debate it this afternoon, so we are keen to hear from the cabinet secretary on matters that are within the remit of the Health and Sport Committee.

I am pleased to welcome Jeane Freeman to the committee in what are very busy and difficult times. She is supported by John Paterson and another colleague from the Scottish Government legal directorate. Thank you for your attendance.

I will start by asking about the provisions for the return of medical professionals to the workforce. That is clearly one of the key provisions of the LCM and the bill in relation to health matters. Do you have an estimate of how many professionals will potentially be involved and will become available with the change in registration requirements? What is your expectation of the ability to recruit such people and the speed of that recruitment?

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you very much, convener. As you have said, I have legal colleagues with me to help with any technical matters. Derek Grieve, who heads up health resilience for us, is also with me, and behind me is Jamie MacDougall—I forgot his surname there, although I have known him since 2016—who deals particularly with social care, learning disabilities and other important areas of that work.

I do not have up-to-date numbers to answer the convener's question, although I will have them this afternoon when I make my statement in the chamber. However, I can tell members that, in the first 24 hours of asking for people, 400 individuals made contact by email or telephone and expressed a desire to return to the workforce. This morning, I agreed the process by which that will happen. To simplify the process, NHS Education for Scotland will become the contracted employer of those individuals, who will undertake a very simple registration and allocation process. That allocation will be based on the individual's location

preference as well as on where using their particular skill set makes most sense.

We will try to do a matching exercise where there are specific skills that we might need—those of an intensive care specialist, a general practitioner or a respiratory nurse, for example. There are particular places where we would want those individuals to work. In addition, there will be extra clinical staff simply to fill rotas who may be happy to be deployed in any role.

That process is under way. As soon as we have the website up, which will be this week, and clarity on how to go about things, we will start to process the people who have already come forward and allocate them to where they can go with all the others. That will include the appropriate use of nursing and midwifery students who are in the final six months of their qualification and year 5 medical students.

The Convener: Are there implications for people who have not yet completed their studies and take on that exceptional role? What will be their position after the emergency, when they wish to complete their studies and register on a permanent basis?

Jeane Freeman: Work is under way with the Nursing and Midwifery Council to enable the experience that is gained from involvement in this context by nursing and midwifery students who are within six months of completing their degrees to constitute completion of their degrees. We expect that those students, like other students who are due to graduate, will graduate in absentia in the foreseeable period; universities are organising that. Year 5 medical students would be going on to the next stages of their training anyway, so they will simply carry on in that way.

The Convener: At the other end of the spectrum, there will be older volunteers who have retired from their professions. Are there special considerations around the position of older doctors and nurses who return to the workforce in these emergency circumstances?

Jeane Freeman: There is provision in the Coronavirus Bill for their return not to impact negatively on their existing pension arrangements.

Special provision might also be made for the number of hours that people wish to work. They will be working in an entirely voluntary capacity. A retired GP might come forward and say, “I’m happy to do two sessions a week.” That is fine. Someone else might say, “I’ll do five sessions a week.” We will make sure that we are very much led by what people are willing to offer, as we should be, because they are volunteering to return to service.

The Convener: Thank you.

Sandra White (Glasgow Kelvin) (SNP): I want to ask about a legal matter. I understand that the powers in the bill will last for two years but that an amendment at Westminster provided that they will be revisited after six months. Will you clarify that, cabinet secretary?

Jeane Freeman: The bill has been amended at Westminster in two regards: the Westminster Parliament will debate the use of the legislation every six months, and the United Kingdom Government will report to the Westminster Parliament every two months on the use of the powers in the legislation.

I understand that, in the Scottish Parliament chamber last week, Mr Russell committed to reporting to our Parliament on the use of the powers in the legislation.

The two-year sunset clause stands; what is important is what is done during that two-year period. Westminster will be reported to and will debate the use of the powers and Mr Russell, who is leading on the bill, has made a commitment to the Scottish Parliament about what he will do.

The other important point to note is that some of the powers that the bill gives to the Scottish ministers and that will have an impact in Scotland will require regulations to be laid. We can make emergency regulations, but if we make regulations to which we want Parliament to agree, Parliament will obviously discuss them. While we have those powers over devolved matters, it will be for the Scottish ministers to determine when to use them and—importantly—when to stop using them.

Sandra White: Thank you for clarifying the point. It is a really important matter. Whether or not there is a sunset clause, two years is a long time, and a lot of people are concerned about the matter. If I understand you correctly, you are saying that, every couple of months, an update will come to the Scottish Parliament.

Jeane Freeman: That is not for me to confirm. Mr Russell is the lead cabinet secretary for the bill as a whole, because it is not only about health. I understand that he said last week that he would report to Parliament. I do not know whether he has put a timeframe on that. Obviously, there is an opportunity this afternoon for that to be tied down if Parliament wishes. I am sure that there would be no difficulty in doing that.

I am certainly happy to return to the committee to discuss the powers that relate to health or social care so that members can be updated on them. Two years is a long time, but it is important to remember that no one wishes to have this emergency legislation or these powers—certainly no one here does, and I do not think that anyone at Westminster or in the UK Government does,

either. The powers are there because of the situation that we face.

As members will be aware from the most recent announcements, the virus is a brand-new one. We are learning about it as we go, and we are trying to anticipate how it will progress. We cannot be certain that it will be over and done with this summer or this year. We do not know that yet, so we need to ensure that we have emergency powers for as long as we anticipate might be necessary—for the maximum length of time that might be necessary. Equally, we can end those powers sooner if we are successful with all the measures that are being taken to suppress the peak level of cases in order to allow our health service to cope with those who are seriously ill and to avoid unnecessary deaths, which is the core point. That is what it is all about, and that is why the emergency legislation talks about two years.

David Torrance (Kirkcaldy) (SNP): Home carers are relied upon by what are probably society's most vulnerable people. Are they going to be given extra training to help to stop the spread of the infection and the same personal protective equipment as national health service staff?

Jeane Freeman: That is not strictly speaking in the legislation, but the answer to that is yes. We now have a streamlined arrangement with NHS National Procurement on taking orders, triaging them and distributing personal protective equipment across the NHS and social care.

Where local authorities believe that they need additional support to provide infection prevention and control training—what I would describe as basic training in barrier nursing—for their care-at-home and social care staff, we will ensure that that is provided. NHS Education for Scotland is exactly the right part of the NHS to do that. That offer is there for local authorities that either employ those staff directly or contract with others for that service. It is then for them to tell us where they need that support and we will ensure that it is provided.

David Torrance: What support is being put in place for carers who fall ill or who are at high risk? Yesterday, I was sent a copy of an email that a company that supplies care sent out to all its staff. The email says:

"There are currently no instructions to self-isolate if you are in a high-risk group. The advice is in relation to social distancing for a period of twelve weeks.

Employees in a high-risk group wishing to remain at home for a period of twelve weeks are classed as technically withdrawing their services and are therefore not entitled to pay."

Jeane Freeman: That is entirely wrong in just about every respect in relation to what we have said and our clear advice about what particular groups of people who are most at risk should do, as well as what we have said, and what the UK Government has put in place, in terms of support for organisations, companies and employees affected in such a way. That includes statutory sick pay, which the legislation will bring in from day 1.

I cannot imagine how the email could be more wrong. I am very happy, in such instances, to be advised directly of organisations or companies that are misunderstanding their responsibilities so that we can ensure that those misunderstandings are corrected.

The Convener: That is helpful—it clarifies the position and sends out that message to employers and employees who are in those circumstances.

To come back to the LCM, in relation to social care registration, I note that the bill extends the period for registration with the Scottish Social Services Council from six months to 12 months. Will that make a significant difference, in view of the timescales that we are talking about around the pandemic?

09:15

Jeane Freeman: My legal colleagues will correct me if I am wrong on this, but my understanding is that that allows the registration of social work students in a temporary capacity in order to enhance that workforce. That is of course a key group of workers in assessing social care needs, and we anticipate an increase in the demand for care at home and social care. The provision gives people a longer period to register fully as registered social workers.

Nobody has contradicted me, so I must be right about that.

The Convener: That is a good sign. I assume that, in broad terms, the same as applies to retired health professionals will apply to retired social workers who are returning.

Jeane Freeman: Yes. Agreements have now been reached with the regulatory bodies that control who is on the register and therefore permitted to be employed in such ways. Those bodies include the GMC, the Nursing and Midwifery Council and the SSSC. The relevant bits of legislation simply ease the process so that it can happen.

Alex Cole-Hamilton (Edinburgh Western) (LD): I put on record my respect and admiration for all that you are doing, cabinet secretary.

For me, the most anxiety-inducing part of the LCM is the provisions on mental health, because there are some pretty sweeping changes in that

regard. I entirely understand the need for some of those changes, such as allowing only one medical officer to report rather than two for compulsory treatment orders. However, we are also suspending the requirement to review compulsory treatment orders, and I have two concerns about that. One is about capacity strain in the system, because we are likely looking at a tidal wave of need in relation to mental health and compulsory treatment orders.

My second concern is along the lines of the issue that Sandra White raised. If the provisions are just left to continue, people could be on CTOs for two years without any kind of review. Does the provision mean that we will not review the orders at all, or is it just a requirement that will be removed?

Jeane Freeman: Is that about the temporary suspension of the mandatory review of certificates?

Alex Cole-Hamilton: Yes.

Jeane Freeman: Right. The general duty to review remains. Part of what is being permitted is to take account of staff shortages—in particular, the provision with regard to having one doctor rather than two. The provisions also apply to the Mental Health Tribunal for Scotland, so that we allow it to continue to function if there are fewer members than would normally be the case. However, the general requirement to review remains.

This is one of the areas that I mentioned earlier in which we require to lay regulations. We could lay emergency regulations, which would last for only 28 days, or we could lay regulations that require to be discussed and agreed by Parliament. Although I cannot predict the future and say that we will never lay emergency regulations that last for only 28 days and on which there is no debate, with mental health legislation, my colleague Ms Haughey is keen that any changes that we make are the subject of at least some discussion by members of Parliament in order to ensure that people's rights are retained.

Alex Cole-Hamilton: It is helpful to have that on the record.

My next question is also on mental health. The bill contains a provision that will allow a person to be given medicine without their consent or if they are unable to consent. I understand why that is there, but I always think about the hypotheticals in such situations. For example, if an elderly patient with comorbidities says, "Don't give me any further treatment—treat the people who need to be treated," would the provision get in the way of their request, or are you content that their rights to have treatment withheld would remain?

Jeane Freeman: We can rest on the professionalism of our clinical staff. Aside from the regulations that govern how they behave and their performance in their professional capacity, those staff also have a strong sense that they have to follow what the patient wants. I do not believe that the legislation cuts across that in any way. If anyone was in those circumstances and was judged to have the capacity to make such a decision for themselves, their wishes would be followed.

Alex Cole-Hamilton: Great. It is helpful to have that on the record. Thank you.

Sandra White: Another area that I, and many others, have a lot of concern about is the extension of the maximum period of detention to 120 hours, and certain conditions that are to be met.

The bill is about the coronavirus, but a huge part of it deals with mental health patients, which I know you explained in your answer to Alex Cole-Hamilton. However, could you clarify for me the rationale behind the specific provisions to deal with mental health patients? I understand that if only one doctor will be required when normally two would be required, that will leave a doctor free to deal to with other medical conditions. Is that one of the reasons why the legislation is making that specific change?

We all know that mental health issues are huge, because we hear about them every day in our constituency offices. The language that is used in the bill and the changes that are being sought could tip some people over the edge. I am not being flippant about that.

Jeane Freeman: We need to be really clear about the distinction between mental health legislation as it impacts on people who are detained in hospital or who are receiving psychiatric care, and as it impacts on people with mental health issues who are adequately—and rightly—dealt with in the community. Scotland has a significant body of important legislation on the rights of people who are receiving mental health treatment and so on. However, there is no body of legislation for patients who are being treated otherwise in acute hospital settings or in primary care, because in some areas of psychiatric care, the balance between an individual's liberties and their health is struck in a different way.

We are introducing emergency legislation to require more flexibility in use of staff in mental health settings, so we will see more emergency legislation relating to that area than to the non-mental-health setting of our NHS. Does that make sense? There is more legislative restriction and provision in mental health than in physical health.

Sandra White: It does make sense. One of the questions that I asked was whether the bill will free up medical staff.

Jeane Freeman: Yes, it will.

Sandra White: However, it will not give flexibility to people who have mental health problems. I worry about people's human rights under the Human Rights Act 1998. That concerns me a lot.

Jeane Freeman: My legal colleagues might want to add to this, but the provisions in the emergency legislation do not permit people to be medicated against their will, or detained unnecessarily. It is not the case that through staffing flexibility we will take people out of a mental health setting to put them in another setting.

The bill takes account of the fact that people will get ill. There will be as significant a level of absence in the mental health setting as there will be in the acute and primary care settings. Either people will be ill and will take time off work to recover or—if they have underlying health conditions—they will not be able to be patient facing, as we would want them to be.

We need to be able to accommodate what needs to be done in the mental health setting with a reduced staff complement without drawing into that setting a staff complement that we need in the acute setting. It is less about being able to move staff from the mental health setting to the acute setting and more about allowing the mental health setting to continue to function with a reduced staffing level without having to draw down staff from the acute setting.

The Convener: You will be aware that the fact that patients are waiting for guardianship can be a cause of delayed discharge—that is, of hospital beds being occupied by people who no longer require them. Is there anything in the bill that will address that and speed up the process? If not, is there anything else that the Government has in mind to free up those beds more quickly?

Jeane Freeman: That is a serious issue that has caused numbers of people to remain in the acute setting when they no longer require that level of clinical care. We have had very fruitful discussions with the Mental Welfare Commission for Scotland about advance planning in those circumstances—in other words, about not waiting until the person is ready to be discharged before attempting to resolve the matter.

We would be very reluctant to remove people's rights in the context of adults with incapacity or guardianship orders unless that was absolutely essential. With a degree of forward planning and redeployment of some of our estate, we can move people from an acute setting to a clinical nursing setting while those processes are gone through. That is important; we do not want the Coronavirus Bill to be seen to be removing requirements to adhere to other important rights-based legislation.

As you will know, we are looking across our NHS estate and more widely to identify where we can free up space in the acute setting by allowing patients who do not require to be in that setting to receive the continuing healthcare treatment that they need—re-enablement for stroke patients, for example—outside the acute setting. We want to make sure that people are in the appropriate healthcare setting while issues around guardianship and so on are pursued.

We had been making progress in high-level discussions with our colleagues in the court world on speedier processing of such matters: unfortunately, the current situation means that those discussions cannot be pursued. We need to consider how, without impinging on people's rights, we can stay within the law and free up space in the acute setting.

Alex Cole-Hamilton: I want to ask about the powers in the bill relating to potentially infectious persons. I am keen for you to explain why two sets of powers are required in that regard. A new power is being created on top of powers that already exist that could be used to control people in that situation.

Jeane Freeman: Could you repeat the first part of your question?

Alex Cole-Hamilton: The bill will give new powers to the police to detain and process potentially infectious persons—

Jeane Freeman: —and we already have such powers under the Public Health etc (Scotland) Act 2008.

Alex Cole-Hamilton: Yes.

Jeane Freeman: That is because we want, given the pace that is needed, to take a four-nation approach, as we have done in respect of the other steps that we have taken in handling the Covid-19 challenge. We did not want to hold up action by having a debate about the fact that Scotland has those powers, whereas England does not. We took the view that we should just take the powers even if we already have some or all of them, rather than cause delay through lots of to-ing and fro-ing on drafting exemptions and so on.

09:30

Alex Cole-Hamilton: That is helpful. I would like to ask about the practical application of the section that deals with penalties for offences

involving people who are identified as Covid-19 patients who are at large in the community. The offences include imprisonment for up to 12 months or a fine. The question with regard to practicalities is: how do we police that? We are asking police officers to put themselves in harm's way to apprehend such individuals. Are we making PPE available to police officers on the street? Where would we take those patients if we were arresting them?

Jeane Freeman: If such a thing happened, the individual would be dealt with in the way in which we would deal with any other individual in terms of infection prevention and control in order to ensure that we minimise the risk of their infecting anyone else. That is self-evident, because that is why we would be exercising that particular power. We would ensure that the process that the person went through prevented follow-through infection.

We need to make a distinction in relation to the powers in the emergency legislation that you could see being used if we had to use them. For example—this is not specifically related to health, as such—there are parts of the legislation that are about enforcing a prohibition on mass gatherings. We do not anticipate that we will need to use those powers, because we believe that people are following that directive—or request, if you like—but they are there primarily because there is a very different situation in England. I do not mean that the powers will need to be used in England; I mean that we have the Public Health etc (Scotland) Act 2008, so there is a different situation south of the border. However, as I said in response to your earlier question, we wanted to co-operate on the legislation that we are discussing today in such a way that we did not delay its introduction by redrafting the exemptions and other clauses when that was not necessary.

Alex Cole-Hamilton: On the other question, are we giving police officers PPE?

Jeane Freeman: Police officers, along with people in the Scottish Fire and Rescue Service, are supplied with PPE in those situations anyway. That is something that would happen in the normal course of things. It is not standard for them to have that but, where they are asked to engage in those kinds of situations, they are protected.

Alex Cole-Hamilton: My question comes from anxiety to do with the fact that the officers are in such a fluid situation. An officer might not know that a situation in which they are patrolling the lockdown will suddenly develop into a case where they are trying to apprehend somebody who is deliberately going around infecting people. In such a situation, they might not have the PPE on their person, so they would have to put themselves at a considerable risk.

Jeane Freeman: Our police force has clear procedures about what to do if an officer is confronted by a situation for which they are not prepared. That covers situations in which someone has a gun, for example. Those clear procedures cover what they do, what they do not do and what aid they can get to deal with the situation. I strongly imagine that their response in the situation that you describe would be to follow those procedures.

We are discussing a hypothetical situation, but I have to say that someone who is deliberately trying to infect others is someone who is unstable and unwell, and that, therefore, they require significant assistance and support, so the situation would not just involve them being prevented from spreading the infection.

The Convener: Given that there are two sets of powers, it might be helpful to clarify the position. Will a person who fails to obey an instruction that is given by a police officer for health purposes be committing an offence and be subject to sanction, and will they will acquire a criminal record, if prosecuted?

Jeane Freeman: Yes.

Brian Whittle (South Scotland) (Con): At the weekend, I spoke—remotely—to a group of dentists, who told me that they have significant healthcare and clinical expertise. They now have capacity and wanted to know whether they could be recruited into the workforce.

Jeane Freeman: Absolutely. Dentists have significant skills, as my own dentist pointed out to me—remotely; he sent me a text. He told me that he was staying open—as I am sure is the case for those whom you spoke to—for non-aerosol-generating emergency treatment, as the chief dental officer for Scotland has instructed. My dentist has a range of skills, and he wants to know how he can use them.

The chief dental officer is pursuing that in order to bring in those from that workforce who wish to assist us across a range of areas, including in acute settings. That work is under way.

Brian Whittle: On surveillance, I know that we have moved on to the sentinel surveillance protocols and that people admitted to hospital with suspected Covid-19 will be tested. However, there are calls to test healthcare staff with symptoms, to stop their having to self-isolate needlessly. My daughter is in that situation, although fortunately she has not tested positive. Are you considering such testing?

Jeane Freeman: Yes, and the statement that I will make this afternoon will go through that in some detail and the steps that we are putting in place.

You will recall—I think that this was set out in Mr Swinney's statement—that there are three categories of key workers. We are starting the testing with category 1, which is the group of critical front-line NHS workers, without whom our response to Covid-19 would be significantly compromised. That is not to say that the other categories of workers are not valuable or important—they are, but this is about criticality and what would happen if we did not have those people. Things would fall over.

We are starting with our current capacity for testing, but a significant amount of work is under way to increase that capacity in Scotland. That is part of a UK-wide additional, significant uplift in the volume of tests that can be undertaken in a day and the speed with which the response can be given to individuals. It is not possible to say more about that now, because final agreement has not been reached across the UK to put that in place. I have confidence that we will be able to announce those measures and inform members fairly shortly. That would significantly increase our testing capacity.

That would largely do exactly what you are asking about: it would allow those healthcare workers who are in household isolation to return to work, if they test negative. I add a qualification to that: the test would tell me whether, at this moment, I have the virus or do not have it; it would not tell me whether I will have it next week. It is a binary test.

The other work that is well under way across the UK and elsewhere is the antibody test, which would tell me whether I have antibodies against the virus. That is a really important test for everyone, but particularly for key workers, because it tells them whether they have the antibodies and are not likely to be affected now. That is different. The work on that test is not as far advanced.

We have the test for Covid-19. It is simply about scaling up the capacity—almost to an industrial scale—and that is under way. The antibody test is being worked on very hard, so that we are sure of it and confident about it. Again, that will be a quick test, once we have it in place. We expect to see that in the near future, but I cannot be more specific than that.

Brian Whittle: In the same vein, I want to ask about the accuracy of the sentinel surveillance approach, given that people are being advised not to present at their GP surgery if they are showing symptoms. Are you confident that the approach to testing and surveillance provides the necessary precision to accurately manage what is becoming a serious pandemic?

Jeane Freeman: I remind members of our announcement yesterday of the establishment of the Scotland-wide community hub and assessment centres, where the advice to people, if they are symptomatic and their symptoms worsen, is to phone 111. Through a series of steps, they will receive the treatment and, if necessary, the hospital admission that they might require, all clinically assessed as they go. That frees up our general practices to continue to deal with non-Covid-related healthcare demands. That is really very important.

Consideration is being given to whether those assessment centres can be included in the sentinel surveillance capacity. We must remember that we are already dealing with people who have Covid-19 symptoms. We are trying to understand the level of spread in the community among people who feel a bit unwell but who do not necessarily know whether they have Covid-19. What we are trying to detect, by testing patients in hospital for respiratory conditions, including those in intensive care, and through the wider sentinel approach, is the grip that the virus has, in terms of spread across our community. That will inform the measures—the prohibitions on what people can do—that we take, lift or change.

You will be pleased to know that that is being worked out not by people like me but by the scientists in our scientific advisory group for emergencies and our clinicians. In addition, the CMO will announce additional initiatives with specific relevance to Scotland. Those are the people who have long experience in infection spread—they understand the epidemiology and so on, and the mathematical modelling and behavioural science. They will come together to work out the best way to give us the intelligence that we, as politicians, will go with. They are the people who understand how we will get the right measure of what is happening in the community.

Brian Whittle: Have the protocols that you are currently following provided you with an estimate of the prevalence in Scotland?

Jeane Freeman: Yes. If I am right, we multiply by 100 the number of Covid-19 patients in intensive care. At the moment, I believe that the figure is 25, so that is 2,500. I think that our scientific and clinical advisers would tell us that that is probably an underestimate, but until we properly get the surveillance data, that is the measure that we will use. The number who are in intensive care—rather than the number of cases—is the critical number. Remember that 80 per cent of people who are infected by the virus will experience mild symptoms and will be fully recovered in seven to 10 days. However, the other 20 per cent will be the most seriously affected; roughly 19 per cent of them can expect to be

hospitalised. More than 50 per cent of those who are hospitalised will require invasive oxygen therapy in ICU and elsewhere. The ICU numbers give us a real indication of the seriousness.

09:45

Brian Whittle: Even those who have mild symptoms are Covid-positive. Would you multiply them by the same number too, to give the overall population who are Covid-positive?

Jeane Freeman: We would not know for sure that they have Covid-19. We are saying that if people have the symptoms of Covid-19, which are a fever and a persistent dry cough, they should stay at home for seven days. The household isolation kicks in on top of that. Those people are not being tested. We cannot be certain that they have the virus. We are being precautionary. Those are the two common symptoms. If we err on the side of caution people with those symptoms most likely do have Covid-19, but we are not running the test to be certain.

David Stewart (Highlands and Islands) (Lab): I read that scientists in China have found that the virus has mutated there. That creates issues for testing, and for the care of patients. Is it too early to determine whether there is any evidence of mutation of the original virus in Scotland or in Europe?

Jeane Freeman: It is too early. SAGE is looking at that data from China and at whether there is sufficient data to reach that conclusion. Scientists require a certain level of data and of evidence before they are prepared to reach conclusions. At this point, SAGE's view is that that data should be constantly reviewed. The World Health Organization will be engaged with that before anyone can be confident that that is what is being seen.

The Convener: What is the Government's advice to pregnant members of the medical and nursing workforce?

Jeane Freeman: The advice to pregnant women is that they should work from home if possible. If that is not possible, they can be at work up to 28 weeks gestation, but their employer should ensure that sensible precautions are taken for them. A healthcare worker should minimise patient-facing contact and should certainly not work in higher-risk areas such as respiratory medicine or in an ICU. They should not be at work after 28 weeks gestation.

Any woman who is pregnant will have a midwifery and obstetric care team. She should seek that team's advice about her own specific case. A woman may have underlying health conditions that would take her out of the general advice that I have just outlined and that would mean that she should not be at work.

Miles Briggs (Lothian) (Con): I want to ask about the provision of personal protective equipment. I know from my mailbag that many health workers are very concerned about that. Can you update us on current supplies of PPE?

Jeane Freeman: PPE includes a number of different items, and there is clear clinical guidance about which items are required for which situations.

I cannot give you exact numbers. We will make sure that we have those numbers from today, but they will be different by tonight. I understand that we have adequate supplies of aprons, gloves, eye protection and normal masks, though not face-fit masks, albeit that there is a challenge with those supplies because we have extended our procurement to cover areas of social or primary care that would not have required them in normal circumstances. There is increased demand over and above that in our acute and hospital settings. UK and Europe-wide availability of the filtering facepiece—FFP3, or sealed face-fit—masks has been significantly challenging. We currently have adequate supplies, but orders are going in constantly.

We have, however, introduced 19 machines at different locations around the country that will test whether the masks fit properly. I am sure that Emma Harper would agree, if she has ever worn one, that those masks are extremely uncomfortable because they seal—you need to be sure that the seal fits. If you were to have a mask fitted, the machine would test the fit and give you the evidence to show that it fitted properly, so that you could be confident of that. In some instances, people have felt that the mask did not fit, although, objectively, it looked as though it did. Now, we have a machine that will give that assurance one way or the other.

You will know that NHS National Services Scotland undertakes that procurement exercise, and you will recall how that worked during the Brexit negotiations and discussions. We are also hooked into UK-wide searches for adequate supplies of all that PPE.

Miles Briggs: Is sourcing and procurement of that equipment being taken forward on a UK-wide basis? The only figures that I could see related to England, not Scotland—I welcome the publication of those figures today. Is this a UK wide procurement or is it Scotland only?

Jeane Freeman: It is both. It is just as it was when we were preparing for Brexit in that we pursue our own routes but we are also part of UK procurement. There is some discussion going on, and it seems appropriate to me that, in some

instances, we adopt a pooled approach so that supplies are allocated to those parts of the UK that need them most at any one time. The key is the supply chain—so that, as allocations are made, we are confident about delivery dates to feed-in.

Miles Briggs: Are all the health boards following the same PPE advice that the Government has given? Specifically, have community pharmacists been included, given that they are picking up a lot of the work in a community setting?

Jeane Freeman: All health boards certainly should be following the advice; if any are not, I would like to know so that we can deal with that. Remember that, last week, I put the NHS on an emergency footing, and it is crystal clear what that means for boards. I met Community Pharmacy Scotland last week, and PPE was among the issues that we discussed. We also discussed Scotland-wide access to emergency care information, which was announced yesterday, as community pharmacists are playing a very full part in our primary care delivery. I was asked to ensure that community pharmacists have the necessary PPE to clean consulting rooms, and we have ensured that that will happen. They are now in the procurement chain.

Miles Briggs: Will community pharmacists be included in the policy on testing kits, when they come forward, as well as NHS staff who want to be tested?

Jeane Freeman: Yes. I have talked about the three categories for testing, and, as we scale up the testing capacity, we will work our way through those three categories.

However, how we will deal with those categories for testing is not the same as how we will approach the categories of people who are being offered the opportunity of childcare, which is Mr Swinney's area. That will not be as strict, because it is not about capacity. I am managing the testing capacity against the most critical group, and, as capacity increases, I can move that to cover other groups in health and social care.

Emma Harper (South Scotland) (SNP): Good morning, cabinet secretary. I know that you are doing an immense amount of work at this time.

I have a couple of questions about critical care. You said that most people will not need to be admitted to hospital; that of those who need treatment about 19 per cent will need hospital admission; and that about half of those will need more invasive oxygen treatment. Looking at the numbers, we know that we will need more critical care capacity. Can you tell us a little more about the way in which critical care is being ramped up? I am interested in machines and ventilators. I am not necessarily interested in numbers, because those will increase as we go forward.

Jeane Freeman: As members will recall, we are modelling the numbers that show where we are in the approach to the curve. The modelling work partly relies on community surveillance, ICU numbers and case numbers, which are constantly changing. As that is modelled, we are mapping the anticipated effect that the measures that we have announced over the past two weeks—including last night—to suppress the spread of the virus are having against the ramping up of NHS capacity. The trick is to suppress the number of cases so that they run just under our maximum capacity in NHS care. That is very difficult to do.

That means that we are extending the length of time for which our NHS will be operating at maximum capacity, which also extends the length of time for which our staff will be operating under considerable pressure. Ms Haughey is engaged in work with boards on what more we can do to ensure the wellbeing and good mental health of our staff, who will be operating under pressure for a long time.

Ms Harper is right about the numbers; from the data that we have had from the rest of Europe and elsewhere we expect that 80 per cent of people will experience mild symptoms and will not require hospital care or, indeed, any healthcare at all. However, those people will need to stay at home and it will take seven to 10 days for them to fully recover. The remainder of people will require healthcare and Emma Harper is right to say that about 19 per cent of that 20 per cent will require hospital care. Slightly more than half of those people will require invasive oxygen therapy. At the moment, the only treatment is high-volume oxygen therapy.

Working through those numbers has led us to the action that we are in the middle of carrying out: doubling our intensive care capacity and increasing our hospital bed numbers by at least 3,000. That is the minimum that we require to do. However, we have also ordered more ventilators than would be required to meet that, which will give us additional capacity. We are doing that because the way in which the virus is now operating and the measures that we are taking to suppress it lead us to believe that there may be an additional smaller peak later on. That is why, later in the meeting, we are looking to pass two years' worth of legislation.

We are maxing out the equipment that we need, even if we never need to use it, on the basis that we could never have too much. That is an accurate description of the decisions that I am taking. I would prefer that we have too many ventilators than not have enough. We also need to take into account the vagaries of delivery dates,

supply chains and so on, and to try to err on the side of caution.

10:00

The work is under way to increase bed capacity by, as a minimum, 3,000. That is why we have paused elective care while retaining urgent and critical care, such as cancer treatment, and it is why we are doubling the number of ICU beds that we have, ensuring that we have the maximum number of ventilators and looking at how else we can increase capacity for ventilator-assisted intensive care as we go forward.

Emma Harper: With increased capacity comes an increased need for training. I know that that is under way, because last Monday I spoke to a respiratory nurse specialist about training.

Issues to do with indemnity have come up. The example that I was given was of an orthopaedic surgeon who is working in an intensive therapy unit to support critical care. How is that surgeon protected if he pushes the wrong button or makes a wee—or a big—mistake?

Overtime came up, too. NHS boards across Scotland deal with overtime differently. It was suggested to me that there should be a single approach to overtime.

Have there been conversations about overtime and indemnity, which the bill mentions?

Jeane Freeman: The bill covers indemnity, to ensure that NHS staff, including returners, are indemnified if they are working out of their specialist area. For example, if we move a urology consultant to another area or if we move our highly trained and skilled theatre nursing staff to work, with additional training, in respiratory and intensive care, they will be indemnified. The bill covers that, and I have reached agreements to ensure that the cost of that is covered.

I am sorry: what was the second issue?

Emma Harper: Overtime was raised with me. If I am a 28-hour-contract person and, all of a sudden, I am doing twice that, I do not get overtime until I meet a 37.5 or 35-hour work week, but I understand that different approaches are proposed in different health boards.

Jeane Freeman: You will recall that, before the current situation, under agenda for change, we had moved significantly, with union agreement, to a series of what were described as once-for-Scotland human resources policies for agenda for change staff. The idea was to remove variation across a range of issues, from annual leave to phased return to work and so on, so that there would be a single approach across health boards.

I cannot recall whether the new suite of policies that was introduced before we reached the current situation with Covid-19 covered overtime, but I am happy to take the issue away and look at it. The less variation we can have in the ways in which staff are treated, the better, because staff are all being asked to do the same thing—and to work under pressure.

Again with Ms Haughey in the lead, we are actively looking at practical things that can be introduced to help staff, for example to ensure that, across all settings, including community assessment centres, there is always a place where staff can have respite from their duties, even though it might be for just five or 10 minutes, and get some hot food or make a cup of tea—that kind of thing.

The Convener: David Stewart will ask brief final questions.

David Stewart: Cabinet secretary, I thank you and your team for the work that you have been carrying out. Perhaps you will pass on my particular thanks to the chief medical officer; I was impressed by her public education advert—if that is the right word—which I saw recently on television.

You talked about ventilators in response to Emma Harper's questions. In previous statements, you have it made clear that, historically, Scotland and the UK have had low proportions of ICU relative to countries in Europe—such as, from memory, Germany, France and Spain—which, obviously, has impact in relation to ventilators.

I will quickly raise three issues. There have been quite a few developments over the past few days in relation to Waste and Resources Action Programme remanufactured ventilation systems. I like the idea that the armaments industry will now do ventilators—from swords to ploughshares, if I may be philosophical.

In addition, there was radio coverage yesterday about UK veterinary surgeons doing an audit of all animal ventilators. I was surprised to hear that they can be used, but, when you think about it, why not? I presume that there is a knock-on audit in Scotland.

You mentioned that it has been difficult to get ventilators, because there is a worldwide shortage. However, there is the use of the rapidly manufactured ventilator system process, and Smiths in Luton is looking at the production of lightweight ParaPAC ventilators, which are currently used by paramedics.

Those are three examples of how you can change the manufacturing cycle, do a bit of diversification and have things on stream. My very

quick questions are: how many ventilators you have, and how many do you need?

Jeane Freeman: We have orders and delivery dates that are enough to double our current ICU capacity; we have orders in that will deliver more than 1,000 ventilators. However, they are staggered over time into midsummer. Those delivery dates need to be met. We have people constantly—literally constantly—in touch with suppliers to make sure that delivery dates will be met. Very helpfully, Germany recently—I think that it was last night or sometime yesterday—removed some of the regulations around export, which makes it easier to speed up those chains.

We have also required manufacturers to batch deliver. Where we have put in an order for 100, they will send us the first 10, then the next 10 and so on; they will not wait until all 100 are done before we get any of them.

On all the other prospects and innovations in relation to modifications that we can make and so on, Mr McKee has set up a group that is looking at reprovisioning manufacturing and linking into the work at UK level. The group is also looking at where there are companies in Scotland that can contribute to the supply chain, and it is reaching out beyond the UK to the network of contacts that, through his role, Mr McKee has in industry and manufacturing to see from where else we can source supplies and where else we can modify—safely and to the right standards—what we currently have.

There are two streams of work. There is the health stream, which is led by the health directorate and which relates to procurement—putting in orders, being on top of the supply chain and delivery timescales and pushing hard on them all the time. Then there is the parallel piece of work—the two are linked—which is led by Mr McKee and which relates to reprovisioning the existing manufacturing base in Scotland and the UK and being hooked into the UK's work on that. That piece of work also relates to reaching out beyond the UK and looking at from where we can source any of the innovations that we read about but whose veracity, availability and immediacy for our current needs require to be properly checked through.

David Stewart: On that note, I flag up one innovation that you might not have come across. I was reading the other day that the engineering department at the University of California, Davis has been developing 3D-printed ventilators. Although they are not as fully functioning as our normal all-singing, all-dancing ventilators, the key is that they are easy to manufacture. I am not quite clear what stage in development they are at; however, 3D printing is certainly an exciting new development. Perhaps the cabinet secretary could ask her officials to look at that as well.

Jeane Freeman: I will ask Mr McKee's officials to look into that. I will make an important point. We need a lot of things in order to meet this challenge, whether in relation to bits of kit or other matters. It is important for us all to know—and, I hope, to be reassured—that there is cross-Government mobilisation on the challenge.

Health has a number of asks that we require other parts of Government to deliver for us. I do not have health officials who are experts in transport or how to manufacture a ventilator—why would I? I do not want all my health officials and health board people, who are busy enough doing what we need them to do, doing that. Other parts of Government are now contributing—it is a genuine cross-Government effort. Therefore, I will get Mr McKee's officials to look at that.

The Convener: Thank you, cabinet secretary. That brings us to the end of our discussion of the LCM. Do you wish to make any closing remarks?

Jeane Freeman: It is worth repeating that none of us—no members of this committee and certainly no members of the Government—wants to be in the position of taking emergency powers of any description, but that is the nature of the situation that we face. We are only doing this—being part of the UK bill—because we believe that the powers are necessary contributors to the work that we need to undertake, which is quite literally about saving lives.

The Convener: Thank you, cabinet secretary. I also thank your colleagues for their attendance. We will write a short report on this morning's consideration of these matters, which will be annexed to the report from the Finance and Constitution Committee. As everyone knows, that will be considered by Parliament this afternoon.

10:11

Meeting suspended.

10:17

On resuming—

Subordinate Legislation

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2020 (SSI 2020/54)

National Assistance (Assessment of Resources) Amendment (Scotland) (No 2) Regulations 2020 (SSI 2020/55)

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2020 (SSI 2020/56)

The Convener: Item 3 on the agenda is consideration of three instruments that are subject to negative procedure. They concern payments that are due to local authority providers from those who live in residential care accommodation. In order to stay in line with inflation, the payment levels are updated annually.

As members have no comments, does the committee agree to make no recommendation on the instruments?

Members *indicated agreement.*

10:17

Meeting continued in private until 10:49.

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