OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 2 March 2021

Session 5

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HEALTH AND SPORT COMMITTEE
8th Meeting 2021, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (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:

Stephen Boyle (Auditor General for Scotland)
Leigh Johnston (Audit Scotland)
Mark Johnston (AGS Airports)
Willie Macleod (UK Hospitality)
Professor Devi Sridhar (University of Edinburgh)
Eva Thomas-Tudo (Audit Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 2 March 2021

[The Convener opened the meeting at 10:00]

Covid-19 Health Protection Travel Regulations

The Convener (Lewis Macdonald): Good morning, and welcome to the Health and Sport Committee's eighth meeting in 2021. We have received apologies from Alex Cole-Hamilton. I ask all members and witnesses to ensure that their mobile phones are on silent and that all notifications are turned off.

Agenda item 1 is a round-table evidence session on the current quarantine, travel and accommodation regulations in Scotland. The purpose of the session is to hear from stakeholders on their experiences of the practical application of the regulations in their sectors, and on the public health implications of those regulations. We have three sets of regulations to consider, which cover a number of different aspects. We expect to take evidence on the instruments next week from the Cabinet Secretary for Transport, Infrastructure and Connectivity, Michael Matheson. Today's evidence session will inform our evidence session with the responsible minister.

I welcome our witnesses: Mark Johnston, who is chief operating officer of AGS Airports; Willie Macleod, who is executive director for Scotland at UK Hospitality; and Professor Devi Sridhar, who is professor and chair of global public health at the University of Edinburgh. I thank you all for joining us.

We move directly to questions. How important are controls at borders and controls on international travel in tackling the pandemic, relative to other measures that may be, or are being, taken? I ask Devi Sridhar to start. If other witnesses wish to answer a question, I ask them to put the letter R in the chat box while the first person is answering.

Professor Devi Sridhar (University of Edinburgh): Good morning, and thank you for having me here today. On travel restrictions, we have now had more than a year to study countries around the world in order to see which countries have more successfully suppressed the pandemic and thereby bought time for vaccine roll-out and other therapies and treatments, and to compare them. It is clear that no country has been able to sustain suppression without having border restrictions in place. The reason for that is simply to do with the gradient in the world. If a country has its numbers come down so that prevalence is much lower, leaving its borders open means that a higher prevalence will come in and keep pushing the numbers back up.

In addition, we now face an additional risk from new variants. This week, we have seen the rise of the Brazilian P1 variant, which is concerning. It is not going to undermine our entire vaccine programme—our vaccines are still very effective at stopping severe illness and hospitalisations—but it is a warning of things to come as the virus circulates in other places.

I will sum up Scotland's position. There are multiple evidence sources to show how low levels came about in Scotland last summer. We can look at the evidence around hospitalisations of those with Covid, the level of death, case numbers and test positivity. In addition, the genetic sequencing work that is coming out can trace lineages and enable us to understand which strains die out and which continue.

From all of that, we can see a lot of reseeding that kicked off our second wave. The same thing has happened in other countries such as Iceland and Greece. We can look around the world and see the same phenomenon—we are seeing it present a continual challenge in Australia and New Zealand, even with their very strict managed quarantine procedures.

Looking forward, if we want to protect against new variants, we need to have strong measures in place while we wait for the rest of the world to catch up, or we can start to form partnerships with other countries that have reached similar levels of vaccine roll-out and suppression. Such measures are a time-limited move until Scotland can get ahead of the pandemic and make a full domestic recovery. That means that, while we are waiting on other countries, we will have a level of protection that many other countries around the world have put in place.

The Convener: You mentioned that there will come a time when we will need such measures less. Was there a time earlier in the pandemic when we might have needed them more? Should we have implemented them at that point?

Professor Sridhar: From the clear evidence that has emerged, we can see that Scotland was in a very good position last June and July. The numbers were incredibly low and, if we had managed to seal off at that point by putting in place protections, testing, quarantine and managed isolation, we could—although we are not an island like New Zealand—probably have prevented the bulk of the second wave.

The test, trace and isolate approach works really well where numbers are low or where there are flare-ups. You might remember that there were outbreaks in factories, which were quickly contained. Even the pub cluster in Aberdeen was managed through local restrictions for a limited time, and we saw the numbers come right down. When too many seeds start being planted all over the country, it becomes a very hard proposition to ask test and trace to manage those kinds of numbers, and we are forced into a lockdown. That point in June and July was the moment.

If we look at countries that have built their travel and tourism sectors back up, we see that they had first to deal with their domestic problem. They could then get their domestic recovery going, which means hospitality, bars, construction and all the other sectors that are needed to ensure that people have jobs and to enable the economy to recover. Those countries then set up innovative partnerships with aviation. Some of the airlines in east Asia are now making a profit, because they have managed to put in place testing and quarantine procedures to make travel safe.

To some extent, the UK wanted to avoid having aviation and tourism collapse, so it tried to stay open, but the result was that those sectors collapsed anyway because few people are travelling, and business travel has stopped. We are seeing much lower numbers in aviation anyway as behaviour has changed, but we have not taken on board the public health benefit of stopping the importation of new strains and variants.

Looking forward, we are in a good position. Everyone says, “How are we going to get out of this?” If the vaccines stop transmission, as it looks like they might, we will reach the stage of vaccine passports. That is already being discussed in the European Union, and countries such as Israel have introduced green cards domestically for people who have been vaccinated.

The situation will be similar to the situation with yellow fever, for which there is World Health Organization certification if someone has been vaccinated. We will reach a stage where aviation will continue, people will be allowed to fly and we can have international mobility, but only when people are vaccinated and we have confirmation that they will not infect others when they travel. Spain and Greece are really keen on that for their tourism industries.

The Convener: A new process is in place after a hiccup or two at the beginning. Is that process working? Do staff in airports and hotels understand it and know what they need to do? I ask Mark Johnston to answer that first.

Mark Johnston (AGS Airports): To be honest, the process was very disorganised and last minute—probably unnecessarily so—when it was brought in. We were looking for a meaningful consultation on its introduction, but unfortunately, given the timescales involved, that could not happen.

I will give you an example. It was announced on Tuesday 9 February that managed quarantine would come in on the Monday, with less than a week to go. At that point, we asked whether there would be a consultation, and we were told that there would not—we were simply being informed that the measure was to be introduced. We did not have anything against its introduction; our concern was simply about the manner in which that was happening.

We asked for another meeting to go through the details because, at that point, on the Tuesday, there was no detail forthcoming on the process or how it would work in practice, which obviously presented us with challenges. Our first meeting on the detail was late on the Thursday afternoon, bearing in mind that the policy was to come into play on the Monday. At that meeting, it became clear that there was almost a blank sheet of paper—there was a real lack of understanding as to how airport processes work and how we would get the process in place properly and on time.

One example related to security clearance. As you probably know, there are stringent security requirements at airports for staff who work airside, beyond security. They are required to have a number of background checks, criminal record checks and so on, and that process can take anything up to six weeks. One of our first questions at the meeting was, therefore, about how we were going to get the measures in place by the Monday if people did not have the proper security credentials. We were told that an alleviation had been granted whereby the contract would be able to operate with a Security Industry Authority accreditation, which is the kind of accreditation that someone gets if they are a bouncer at a nightclub.

We were obviously very much against that, as it goes against everything that we try to do to ensure airport security. We managed to find some safe workarounds, but we followed it up afterwards with the Department for Transport, which told us that, if we had put such a measure in place, we would have had a deficiency notice. That exemplifies the challenge that we faced in trying to introduce the policy in haste at the last minute.

Glasgow airport had all its international flights cancelled from the end of January, and Aberdeen airport had two flights a day for the oil and gas sector. Edinburgh airport still had some international flights, but our primary focus was on

what was going to happen with flights coming in through the likes of Heathrow airport.

On the Thursday, we asked how that would work, because the Scottish Government policy of blanket quarantine was different from the United Kingdom Government's policy of red lists. We were told that anyone flying into Heathrow, for example, would have to quarantine at that point of arrival before they could travel up to Scotland. However, that policy seemed to change a few times—by the Friday, that was no longer the case. On the Monday, we discovered a loophole—it was reported in the press that some customers had flown in to Edinburgh airport and had ended up in a hotel, but were subsequently able to leave within a few days because that went against the policy.

Your question was about how well the new process was understood. For customers, it was very difficult to understand. For us, given that it was put in place quickly and without any consultation, it was difficult to understand. That led to a number of problems when it was first implemented.

The Convener: You mentioned a meeting on the Thursday at which you were told that you could follow a certain route in relation to airport security, which the DFT would have regarded as deficient. For clarity, was that route suggested to you by Scottish Government transport or health officials? What was the source of that suggestion?

Mark Johnston: There were many people on the call. The health officials would not have made that suggestion, because it was to do with transportation.

Willie Macleod (UK Hospitality): Good morning, everybody, and thank you for the opportunity to put some views to the committee this morning. The lack of international travel has had a very significant impact on our sector, as it has on many sectors of the economy.

Focusing on the hotels part of our industry, I note that, last year, hotels had quite a bit of experience of remaining open for key workers while other parts of the hospitality sector were closed down. As far as I am aware, all hotels put in place well-managed protocols to enhance hygiene and customer safety. Hotels had a good track record of accommodating people—key workers such as national health service staff and utility and transport workers—who needed accommodation, albeit that they were significantly restricted in their operations and what they could offer their guests.

On the introduction of quarantine hotels, I certainly agree with Mark Johnston that it came about at very short notice. My London colleagues were involved with the UK Government in identifying suitable operators, including those that are located at or close to Scottish airports, and hotels dealt with a procurement contractor that was appointed by the UK Government. They submitted tenders or expressions of interest against a pretty detailed specification. We ended up with six quarantine hotels in Scotland, although I understand from speaking to a company yesterday that at least one of those hotels has been stood down because demand does not seem to be as high as was expected.

10:15

As I mentioned, hotels have put in place pretty extensive operating and hygiene protocols. They are used to looking after their guests. In the main, it is major chain hotels that are providing the quarantine facilities. They have experienced safety and security personnel and standard operating procedures in place, and they have undertaken risk and safety assessments. In general, their staff were given the option to opt out if they did not want to work in that environment. Testing is in place for staff as well as for those who are quarantining. I think that at least one company would have preferred to have had the opportunity and the lead time to vaccinate its staff, but that was not possible, especially as it takes three weeks for the vaccination to become effective.

In general, the arrangement is working well. It involves a very small proportion of our industry throughout the UK and in Scotland, and the hotels that are involved have risen to the occasion. Late last week and earlier this week, I was checking around with companies that are involved, and it seems to be going fairly well.

The Convener: I remind our witnesses that they should feel free to put the letter R in the chat box if they want to supplement an answer from a colleague.

Emma Harper (South Scotland) (SNP): Good morning. Willie, you said that a hotel has been stood down because demand has been lower than was anticipated. How many people have entered managed isolation in Scotland so far? Are the numbers higher or lower than the projections?

Willie Macleod: I am afraid that I do not have that number. It is not something that UK Hospitality, as an organisation, has been tracking. However, as Mark Johnston mentioned, the number of international flights into Scottish airports is fairly limited at present, and I am hearing anecdotal evidence that, since the quarantine restrictions were put in place throughout the UK, flight load factors have in many instances been much lower than might normally be expected even at this time.

Only one hotel out of six—I think that it is at Edinburgh airport—has been asked to stand

down, although, as far as I am aware, its arrangement with the UK Government remains in place in case it is required in the short term.

Emma Harper: Thank you for that answer. I hope that somebody is monitoring how many people are entering managed isolation. I know that flights, airports and passenger journeys will have been affected.

Going back to the consultation process, I have a question that might be for Mark Johnston. We know that the regulations were brought in really quickly, and from what you say, it sounds like there was basically no consultation—you were simply told to get on with it. Would you not have flagged up, or been aware of, such a policy, given that other countries such as Australia and New Zealand had put in place managed isolation? Would you not have undertaken as part of your normal process to look at what was happening elsewhere in order to ensure that you were at least prepared to engage in a process of managed isolation and to prepare for the associated requirements?

Mark Johnston: We were aware that managed quarantine was going on in other countries around the world. Our frustration with the lack of consultation was because the policy was signposted by the Government in the middle of January and confirmed at the start of February. We do not own the process—it is owned by the Government. We cannot start speculating on the process, therefore, because there are so many variables that we would not know where to start.

What we would have liked to happen was, at the point when we knew that there was a serious probability of the policy coming into play, for us to sit down and start to have a discussion to work out what the process was, who was taking accountability for each part of it and how we could make it work smoothly and safely. Unfortunately, when things happen at the last minute, it is very difficult to do that. We are a willing partner and we want to make the policy work, but the lack of engagement made it very difficult for us, and for the customer as well.

Emma Harper: Is dialogue continuing between the Scottish and UK Governments and the other players that are involved in order to manage the whole process? I assume that, if we continue to need managed isolation, we will need to continue that dialogue.

Mark Johnston: Yes. The process is essentially set up now. The contractors are on site and we have an understanding of how it needs to work. As was alluded to earlier, with the controls that are in place, no one is flying internationally, or certainly not into Glasgow or Aberdeen airports; it is only the oil flights at Aberdeen that have an exemption. We must take care to ensure that, if and when things start to alleviate, we can still manage the process effectively with any number of passengers.

The Convener: I have a quick question for Mark Johnston. Between the period when controls were already in place in January and the period after mid-February when managed isolation procedures came in, was there a further drop-off in travel, or had all international flights ceased before the system was brought in?

Mark Johnston: All the flights—[*Inaudible.*] We finished last year with a slightly positive outlook for this year, but things moved very quickly with the full lockdown in January. We still had some KLM flights to Amsterdam and some Emirates flights to Dubai, but they had essentially finished by the end of January.

Brian Whittle (South Scotland) (Con): Good morning, panel. I have some quick questions about the procurement of hotels and some of the services there. What has been your experience of the procurement process for hotels? What additional requirements have hotels had to demonstrate to ensure that they can deliver effective infection control? Has the procurement process been straightforward?

The Convener: I call Willie Macleod.

I do not know whether we can hear him.

Willie Macleod: Can you hear me now?

The Convener: Yes, we can.

Willie Macleod: Sorry about that.

I have not been directly involved in the procurement process. I believe that the UK Government’s procurement agency contacted hotel companies that might be sufficiently well equipped to deliver the service. One of the overriding criteria would have been proximity to, or location within the curtilage of, the airport, in order to minimise travel.

From memory, a nine-page or 10-page specification was issued to hotel companies that were interested in delivering the service. It covered topics such as hygiene protocols and the specification for the meals that would be provided, and a protocol for their delivery. It also covered the arrangements that would need to be in place to allow people in quarantine to undertake cleaning and housekeeping themselves, given that no one should enter the room to provide cleaning or housekeeping services. That included arrangements for the handling of soiled linen and rubbish that would be generated in the room.

There were also specifications on dealing with the security staff, who would be appointed separately, under a different contract. If memory

serves me correctly, there was something in there about dealing with the transport staff to take passengers from the airport to the hotel, and the provision of meals for those staff.

In many cases, as I said earlier, the hotel industry had already put in place Covid-related safety procedures. UK Hospitality produced a significant manual to enable all sectors of our industry to operate as safely as possible. In Scotland and across the UK, the entire hospitality industry was working to guidance that was produced by the Government. We co-operated with the Government in its production.

The cost of quarantine was set by the UK Government, not by the hotel companies. The hotels would have submitted pricing estimates for delivering the service that was required by the Government.

That is about all that I can say offhand about the procurement process. I understand that it worked fairly well, although it was done with very short notice. There was quite a bit of working at pace, as they say.

Brian Whittle: Thank you for that full answer—I appreciate it.

For a hotel company, operating a quarantine hotel is obviously not the norm, and that must have an impact on the business. What is the effect in that regard? How long are hotels locked into contracts for? Would they continue to be excluded from hosting other guests as and when restrictions are lifted? How do the contracts affect other aspects of Covid-19 business support?

I appreciate that there are a few questions in there.

Willie Macleod: I do not know how long the contract lasts, but each of the hotels in question was contracted on the basis of exclusive use, so they would not currently be able to accommodate any other guests. Quarantine or managed isolation apart, hotels were able, under the current general restrictions, to deal only with key workers and other people in a very limited range of circumstances. Moving to operate under the quarantine arrangement would not have affected their normal business, because there is currently no normal business.

If I remember correctly, there is a requirement in the contract that, when a guest leaves the room, it has to be vacated for 72 hours before housekeeping staff can enter it for cleaning purposes. It would then be subjected to a deep-cleaning regime—I cannot remember whether that is specified in the contract, but it would certainly be covered in the hotel's standard operating practices. When a hotel's quarantine contract ends, therefore, I would imagine that, within 72 hours or a little longer, the hotel would be cleaned and could return to normal operations.

Brian Whittle: I have a very quick question to finish. What input has there been from the unions regarding quarantine hotels? Have they been involved in discussions?

Willie Macleod: I do not know whether the trade unions were involved with the UK Government. As far as I know, the hotels involved dealt directly with the Department for Digital, Culture, Media and Sport. I understand that the UK Department of Health and Social Care was also involved. I do not know whether the trade unions were involved in those discussions—[*Inaudible.*]—between the hotels and any unions that they recognise, or any staff associations. As I said earlier, one of the companies that I spoke to had explained the situation to staff in some detail, and they were given the option of electing whether to work in those circumstances. I understand that, on average, about 12 or 15 staff are working in the hotel to deliver the service and, in addition, the security staff are there.

10:30

The Convener: I anticipate that that question will be addressed at some point by Gary Smith of GMB Scotland, who had hoped to appear this morning but is unable to be with us.

Sandra White (Glasgow Kelvin) (SNP): Good morning, everyone, and thank you for coming along today. I want to explore in slightly more detail the issues with the contracted security staff.

We know that there is a four-nations approach and that the UK Government is responsible for isolation, quarantine and security. I was interested in what Mark Johnston said about the fact that security accreditation would be provided through the SIA. He is absolutely right to say that that scheme is used for bouncers. Normally, people have to pay for the accreditation themselves.

Devi Sridhar mentioned the situation in Australia, which introduced isolation way back in March 2020. There has been a lot of coverage of the security situation in hotels in Australia. When Ireland was talking about putting people under security and isolating them, it was reported that Professor Mike Toole

> "raised the alarm"

and said that the use of private security firms was

> "'entirely inappropriate' and Ireland should heed the Australian experience, or pay the price."

In our country, as a result of the UK's insistence that we go through that process, G4S is the security firm that has the contract. Professor Toole said of the private security staff in Ireland:

"They don't get standardised training, they don't get standardised supervision, they can have two jobs or three jobs. It's a disaster. That's what led to the second wave in Melbourne."

Do the witnesses have any views on the use of contracted security staff to deliver managed quarantine? As I said, the contract in Scotland has been awarded to G4S, which has had quite a lot of press coverage. My local paper, the *Glasgow Times*, had quite a big article on the situation. I simply throw that question out there, if anyone wants to comment on it.

Mark Johnston: The point that I would like to make—maybe I did not make it clearly in response to the previous questions—is that the contract is directly between the Government and G4S. The airport is the landlord. We follow the processes, but those are set out by the Government with G4S.

Could things have been done differently if we had been engaged in the process earlier? Potentially. Do we have any issue with there being a contractor? No, as long as the process works properly. There were a lot of teething problems, but we were not party to the whole procurement process. The contracting of G4S was done not by us but by the Government, which engaged directly with the contractor.

Willie Macleod: I have not been made aware of any difficulties regarding security staff. As Mark Johnston said, the contract was let by the Government, which engaged directly with the security firms. I believe that the transport contract was also separate.

If I recall correctly, in the tender specification for hotels, there was no responsibility on the hotel management to supervise or manage the security service, other than to provide those staff with accommodation for rest breaks and meals. The management was down to G4S.

The Convener: I call George Adam.

Sandra White: Sorry, convener—I have a follow-up question. I thought that Devi Sridhar could answer it.

The Convener: Sorry, Sandra. You have a further question.

Sandra White: I mentioned the newspaper coverage of what happened in Melbourne in Australia and the situation in Scotland. Basically, people felt that they were being treated as if they were in prison, because there are G4S security guards in prisons, too. I remember Jason Leitch saying that it should not be like that. That is why I raised that particular point. We should not forget that it is the UK Government that has brought those arrangements forward.

My follow-up question may already have been answered. In light of the situation with G4S, what training and other safeguards should be put in place regarding the use of contracted staff? Do you have any leeway in ensuring that people do not have two jobs, for example? Are there ways to ensure that the use of those staff does not lead to the kind of outbreaks that we have seen in Australia?

That is my last question, convener.

The Convener: Thank you, Sandra. Does Devi Sridhar want to add anything to the replies that we have heard from the other witnesses on that issue?

Professor Sridhar: Yes. It is clear that very strict arrangements are needed for training staff, in addition to there being adequate protection for them. There is also a need for greater awareness of the aerosol dynamic of the virus. We have learned a lot in the past 12 months. At the start, there was a huge focus on washing hands and on fomites—substances, basically. We have since learned that the aerosol that is spread through the air in poorly ventilated settings is just as important. Australia has said that it is seeing from its hotel quarantine experience that it needs to be attentive to the need for ventilation and the spread of the virus in that way.

We need to use testing as well. We need to have multiple checks in place. As we go into the future, those multiple checks will have to involve a negative test on arrival in addition to testing at the airport or after three days, and then testing at five days. We cannot stop everything—that is one of the lessons that we have learned. We will have to deal with flare-ups. Nevertheless, the more layers of protection and safeguards we can put in, the more robust our system will be.

George Adam (Paisley) (SNP): Good morning, everyone. The front-line staff in all the organisations that are represented here today are the ones who face the risk of infection every single day. Are all staff who are working in airports, providing transport, working in hotels or providing security support adequately protected from infection? If they are, what changes have your organisations or industries made to ensure that those protections are put in place?

Mark Johnston: The safety of our staff has been paramount throughout the pandemic. As you probably know, the airports have remained open, with key workers in place. Very quickly, we had to establish safe systems of working, with risk assessments in each area. Those varied from the maximum amount of people allowed in a restroom at any one time to social distancing and the use of personal protective equipment whenever it is required.

We have been in the pandemic for nearly a year now and, to be honest, the airports have been relatively empty for the most part. When we thought that we would start to get somewhat of a summer getaway last year, we had to be more careful and plan for more passengers in the terminal. However, I am pleased to say that we have had very few, if any, flare-ups or instances of someone passing on the virus to someone else at work. We are happy with the provisions that we have in place, but we will not be complacent, because we need to look after our staff.

Willie Macleod: Again, I revert to an earlier response that I gave. The businesses that are involved in providing a service, if they are doing so at all, are putting in place procedures that are more robust than normal. When hotels were operating, they all had to abide by Scottish Government guidance, and many of the companies had their own operating processes to deal with Covid. Although UK Hospitality produced a manual that ran to several hundred pages of guidelines for different types of business and different hospitality and accommodation settings, I would say that most—probably all—businesses were observing those protocols rigorously anyway.

In the quarantine hotels, there will certainly be PPE available to staff and stringent hygiene arrangements in the public and staff areas of the property. If any hotel staff are—[*Inaudible.*]—and the quarantining guests—[*Inaudible.*]

One of the lessons that was learned from Australia relates to what Devi Sridhar said about aerosol transmission. There was one incidence of transmission in Australia where people who were in rooms directly opposite each other in the corridor of a quarantine hotel opened their doors at the same time when meals were served—meals are left outside for guests to take into their rooms—and the infection was transmitted from one room to another. From that experience, we learned the lesson that the delivery of meals should be staggered to minimise the risk of people quarantining in different parties coming into contact with each other and occasioning a transmission. In general, however, I would say that the safety of staff is paramount. There must be some co-operation between hotel staff and the security staff to ensure that they are all operating to the same protocols.

Professor Sridhar: [*Inaudible.*]—the safety of staff and those who are working in quarantine facilities. Australia has started its vaccination roll-out in those places, because that is where cases are most likely to be seen.

In the UK, we have a different problem. We have had substantial community transmission, so it made sense for us to start the vaccination programme in the community, by vaccinating those who are most at risk of death. Looking forward, if we have an ambition—which I think is feasible—to vaccinate all adults, which would include all those who would be working in such facilities, by mid-July, and those in high-risk groups possibly much sooner than that, we will be heading into a better position in terms of the safety of people working in those settings.

The issue of vaccinating teachers, police officers and so on was considered by the Joint Committee on Vaccination and Immunisation, which—as you will have heard—determines the priorities for vaccination. The JCVI decided not to prioritise those groups at the moment. From my reading of the advice that it gave, there was a practical issue. The way in which the NHS is centred means that it can move faster by age—we have seen how fast it is moving. If it had to move by occupation, that would slow the vaccination programme down. The JCVI said that, if we wanted to cover the largest amount of people in the fastest time, we would get down to the 40-year-olds and 30-year-olds faster if we went down the age route than if we went down the other route.

For those who are planning for safety in the next few months, the vaccine will really help with that, and it is not light years away—it is just months away, as we head into the summer. If traffic picks up as we head into autumn, it will help to protect those who are on the front line.

George Adam: Most staff are now working under more mental strain than was the case previously. How is the mental health of staff supported in the hospitality industry or in airports?

Willie Macleod: It will differ between companies, but all employers have a duty of care to their staff, whether that is for their physical health or their mental wellbeing. One starting point will be to train staff as well as possible and to reassure them. In addition, we need to listen to any concerns that staff raise and address those. If any member of staff has particular concerns or is exhibiting particular problems, it is incumbent on the management of the business to address those.

Mark Johnston: That is a good question. We identified early on that mental health was a big problem. Living through a pandemic is not easy for anyone. We have in place an employee assistance programme, which means that anyone can pick up the phone and speak to someone 24 hours a day to get support with their mental health or any other life stresses. Our chief executive, Derek Provan, does a blog every two weeks which is cascaded live to the entire workforce. He has introduced someone who is a mental fitness practitioner, as he calls it, who has been running separate sessions for the whole group to help everyone to deal with the pressures at work and

the pressures of a pandemic. That has been extremely well received.

10:45

George Adam: I have one final question. I have a constituent who has business interests abroad and uses Glasgow airport quite often, as Mark Johnston will no doubt be glad to hear. My constituent told me that, in the past year or so, he has spent probably the equivalent of two months in isolation at home, given that he has done two weeks of isolation after each trip.

In your opinion, are the general public complying with the regulations and guidance? I can see that that could be quite challenging for someone who is in the situation that I have just described. What is the protocol if someone does not comply?

Mark Johnston: Again, that is a good question. We are not privy to that information. We have asked that question a number of times in order to find out how effective isolation is, because—as you say—isolation works only if people follow the process. We have been campaigning for the best part of a year for testing on arrival—which was mentioned earlier—and for test and release. We commissioned some work from a health practitioner at Edinburgh airport, and we worked with the Government for nearly five months on a proposal that was to be taken to ministers. Unfortunately, that was dropped at the last minute, and we never got to find out what was proposed to ministers. We genuinely believe that testing is the safe way out, because we cannot have the current restrictions in place for a long period of time.

Willie Macleod: I refer the committee to my earlier answer. As a trade body, UK Hospitality would recommend good management practice in respect of staff and their health. Mark Johnston outlined the sort of arrangements that a good employer would put in place, and we would encourage individual operators to adopt that type of behaviour.

The Convener: Absolutely—I was looking to discover, following on from the earlier question, whether you had had the same experience as Mark Johnston, in terms of not being able to establish how effective the system is in respect of public compliance, in line with George Adam's question.

Willie Macleod: From the feedback that I have had from the businesses involved, compliance seems to be fairly universal on the part of the people who are required to quarantine. The actual management of compliance is down to the security staff, and it falls very much within the terms of the security contract. The individual hotel, and its management, would be concerned if there was any failure to observe the conditions of quarantine. A first referral would be made to the security staff, before moving to any fallback that the contract may contain.

David Stewart (Highlands and Islands) (Lab): Good morning to all our witnesses. I am keen to hear more about the international experience. I am interested mainly in Covid passports, which were mentioned earlier. I have raised the matter with the First Minister and, at the COVID-19 Committee, with the Cabinet Secretary for Health and Sport. I have observed that the European Union is marching ahead with its Covid passport plans, and airlines such as Qantas are looking at the issue.

My view is that I can see the world's economy, and tourism in particular, being managed and operating in any way like normal only if we have an internationally recognised passport, which could perhaps be issued through the World Health Organization. It could be of a digital nature, and it could also give test results. We could look at using an app, such as the Protect Scotland app that we currently have.

Before I ask the witnesses for their comments, I note that I am very conscious of data protection and individual liberty issues. There is obviously a difficult balance to strike in that regard. The main focus would be on access to travel, rather than access to day-to-day services; I understand that there are more social and individual liberty issues with the latter aspect. I am keen to hear the views of witnesses on those proposals.

Professor Sridhar: That is a great question. You are absolutely right that a Covid passport is where the world is going, although it brings in real inequality issues. I should mention—I did not know that you were interested in the matter—that our team has just finished a report in which we reviewed the international experience in that respect; I would be happy to share that with you after the meeting so that you can have a read through. I think that we are heading that way. As you said, the EU is already discussing vaccine passports in order to remove quarantine restrictions and restore free movement.

There is also something called the Commonpass app—I do not know if you have come across it—which involves a partnership between JetBlue, Lufthansa, Swiss International Air Lines, United Airlines and Virgin Atlantic. It is an app to which people can upload their medical data, their Covid test result and their proof of vaccination from the hospital, and they then get a pass, in the form of a QR code, that allows them to fly. Airlines are already heading in that direction because they know that that is the way that we can get travel back.

The reason that the WHO has not moved in that way is because we do not yet know conclusively that vaccination status reduces the risk of transmitting the virus to others. Based on the data from the past few months, we know for sure that the Pfizer and AstraZeneca vaccinations reduce the chance of hospitalisation, and we know that they reduce the chance of death. We are seeing signs—there was a study of health workers coming out of Cambridge, and a study from Israel that looked at social care workers—that vaccination seems to reduce the levels of people becoming infectious. That is brilliant, because, in a way, it is the missing piece. Once that is conclusive, the WHO will move towards such a policy.

The other reason that there would be a pushback against such a scheme is because vaccination access around the world is very unequal. The UK and Scotland will be done by mid-July, but 130 countries have no vaccines, and little chance of getting access to any Covid passport. That leads to questions about whether such a scheme would create a two-tier system, whereby only those in richer countries would get a passport. Lufthansa is already offering a service whereby people can fly to Russia to get vaccinated and then fly home, for those who want to get ahead of the queue. We are seeing that in the United States as well.

There is a pushback around the ethical issues, but a passport is coming. The next stage, as you mentioned, involves domestic use. Spain and Greece are looking at passports even for access to clubs and bars. Israel has introduced a green pass system, which is also about encouraging young people to get vaccinated. Many people in their 30s think, “Why should I get vaccinated?” However, they play an important role in spreading the virus—Israel has shown that vaccination of 20 and 30-year-olds is what stops the virus spreading. As we know, it is those aged between 20 and 40 who spread it; the people who suffer are those who are over 60 or who have health issues. That is the problem with Covid: the people whom it affects are not the people who spread it. We can start to create an incentive for people by saying that if they want to go to a concert—if they want to be able to be active in the places where spreading occurs—they have to be protected and make sure that they do not infect others.

We are heading towards such a system—I think that you are right about that. Scotland needs to be ahead in preparing for it and thinking about how, if we are going to do it, we can do it properly.

David Stewart: Thank you—that is helpful.

Mark Johnston: As Devi Sridhar described, the idea seemed to have a lot of momentum and then it went a bit quiet, but it has now gained momentum again. As an industry, we will support whatever the simplest means are to enable a safe return to flying. It looks as if a vaccine passport is a good option in that regard

In the short to medium term, we have quarantine, but the longer we have quarantine, the fewer people are going to fly. We want a safe return to flying. There are a lot of complications with a vaccine passport, but they need to be ironed out, because that certainly looks like the front runner—with the addition of testing when it is required—for bringing us back to some kind of normality.

David Stewart: I thank the witnesses for their very helpful contributions on that issue.

My final question focuses on the Australian experience, which was touched on in earlier responses. I would be interested, for the record, to hear the witnesses’ views on the Australian experience of quarantine hotels, and specifically on the case for a different quarantine period. As you will know, the quarantine period in Australia is 14 days, whereas in the UK it is 10 days. I would be grateful for your views on that.

Professor Sridhar: That issue has been much debated across countries. Some places, such as France, have dropped the quarantine period down to seven to 10 days, while Vietnam is at 21 days, because it is worried that some of the new variants have longer incubation periods. As we have seen, the longer the quarantine period, the harder it is to have international mobility or any kind of aviation support.

We are realising that it is very difficult, in a place that is as connected as Europe, to be as isolated as Australia or New Zealand. It is hard for a country to completely seal itself off. To better explain the rationale, 10 days catches the bulk of cases. You can reduce quarantine to 10 days with testing, and be pretty sure that you will catch 80 to 90 per cent of cases. You will not catch 100 per cent, but a 10-day period, along with a test and trace system, means that you can keep the virus at elimination levels, or what we might call “low endemic”. There will be flare-ups and clusters.

I would use the analogy of measles, not because the viruses are similar, but because of how we manage it. It is not that we never see measles—we see outbreaks, but they are handled quickly, and our system can respond to them because we have pretty good public health responses for small-level infections. The 10-day system is about saying that we can shorten quarantine, have higher compliance and use testing to try to get around some of the issues around the risk of releasing people earlier than 14 days.

There is an issue with the new variants. Looking ahead, I am slightly worried that if a new variant with a longer incubation period emerges, it will have a selective advantage. It would be able to evade our current systems of response, which means that it would spread more. As scientists, we have constantly to evaluate whether the incubation period has changed and whether our advice needs to change alongside that.

Right now, 10 days seem suitable, but that could change in a month or two as more and more variants emerge. We are at a crucial moment with variants because of the selection pressures, which mean that variants that are more transmissible—as we have seen with B117, which has taken off in Scotland; it has gone from a few cases to being the dominant strain—are starting to emerge. The challenge is going to be that any advice that we give will have to shift according to the behaviour of the new variants and the scientific evidence on how long the incubation period is.

David Torrance (Kirkcaldy) (SNP): Good morning to our witnesses. The UK's scientific advisory group for emergencies has concluded that:

> "mandatory quarantine of all visitors upon arrival in designated facilities, irrespective of testing history, can get close to fully prevent the importation of cases or new variants".

That is important, given that three cases of the Brazilian variant were announced in Aberdeen yesterday. What is the scientific evidence for the current international travel restrictions in England, particularly for the use of red lists for acute-risk countries?

Professor Sridhar: I do not think that it makes much sense to focus on red-list countries. The reasons for that are twofold. First, the way in which people connect and move is such that they will try to evade travelling from a red-list country. I will give you an example. If someone flies from Brazil, which is a red-list country because of the variant, to Madrid, and then on to London, they will be on a flight with many other people who are flying only from Madrid to London. When the flight gets to Heathrow, the people who are flying only from Madrid to London can go home, while the people who are flying from Brazil to Madrid and Madrid to London have to go into managed quarantine, but they have all just sat on a flight together for two hours. Do you see what I mean? It does not make much sense, because the risk is pooled.

That is why, early on in the pandemic, even when President Trump—the former President Trump, I should say—was talking about a China travel ban, he was slightly—[*Inaudible*.]. We can restrict travel, but a lot of the importation in Scotland did not come from China. It did not come from Wuhan—it came from Italy, Spain and France. It is very hard to predict exactly where importation is going to come from, given how people move.

That brings me to the second point, which is that we have sequencing in places such as Britain and Denmark—and now, increasingly, in the United States—but most countries in the world do not have it. The red list shows only those countries where the virus has been detected. It has been detected in Brazil and South Africa, but there could be strains circulating in Malawi or Lithuania—we do not know. We are therefore flying blind. We are reacting, but by the time that we have reacted, the virus has probably already been seeded here and is spreading.

The Scottish approach is wiser, because we want to quarantine either anyone who comes in, or no one who comes in. If you just do it halfway, you take the hit. Fewer people will fly, because travel is disrupted, but you will not get the associated benefit of actually catching new variants as they emerge and come in. There is a misunderstanding, in that people say, "We can't shut down the world forever." Nobody is saying that we should shut down aviation forever. We are saying that we should build up the system while our vaccinations are going on in order to proceed safely, and then people will fly, and airports and airlines will have a more robust recovery when people fly with confidence as they know that they will not infect others or be infected. There are appropriate testing and vaccination procedures in place, as well as—increasingly—quarantines, until we can get around that.

Mark Johnston: To add a bit of context to the learnings, border policy is down to Government, and it will control that. Our understanding of what has happened in Australia and New Zealand is that the Governments have moved to effectively close the borders with managed quarantine, but they have also put money into the sector to the tune of hundreds and hundreds of millions of dollars.

11:00

My point, therefore, is that you cannot put in place a measure such as managed quarantine, which effectively shuts down aviation, without looking at and understanding the consequences. We have had no flights for nearly a year, and passenger numbers are down by 98 per cent from where they were this time last year. Unfortunately, we have lost more than a third of our workforce—thousands of jobs have gone.

We are very grateful to the Government for confirming the business rates relief, but sadly that amounts to less than 8 per cent of our fixed costs,

while we remain open to keep the country moving. We will have burned through that money by the end of week four of the new financial year. In times when the restrictions are as severe as they currently are, it is extremely important that we recognise that airports cannot keep operating with such high fixed costs. Sector-specific support is required if such policies are in place.

Donald Cameron (Highlands and Islands) (Con): I have a general question. How effective has the four-nations approach been on international travel? What practical challenges have arisen? I ask that question in the context of the fact that Scotland's approach is different not just from that in England, but from the approaches in Wales and Northern Ireland.

Professor Sridhar: The four-nations approach has been challenging, because there has not been full alignment between what number 10 is saying about UK-wide policy, with the red list, and the Scottish Government's aim of trying to stop all variants coming in from anywhere. It comes down to differences in strategy and what we are trying to achieve in respect of the virus, which remains to be seen.

To be completely honest, I do not think that anyone knows how the virus will look in the next three years. We have different theories about how it could evolve. One theory is that it could become like a common-cold coronavirus and circulate. Unfortunately, however, when the virus has mutated—as we have seen with the Kent variant, or B117—it has changed to a more transmissible form. That means that it is more like the common cold, but at the same time it has become more severe and is causing more hospitalisation. It has not gone the way that we wanted it to go—it seems to be going in a different direction.

We are now seeing a need to align on where we want—[*Inaudible.*]—to be. As I have been saying for more than a year, my view is that we need to drive the numbers really low, because the lower the virus numbers, the more freedom and economic recovery we will have. We can see that in the countries that have performed better; analysis by McKinsey & Company and others has said the same thing on the economic side.

However, I think that there is a feeling in England that we can live with the virus, in the way that we do with seasonal flu, and accept a certain number of cases, which means that we can be more lax in our international policies. We would accept, for example, that—based on the SAGE modelling—there would be 30,000 deaths in the coming months. We accept 9,000 deaths a year from flu, so why would we not accept 30,000 deaths? I have heard the same debates in the States. Do we simply accept a certain number of deaths, and say that that is just how it is? That is quite a difficult proposition right now, because the virus is so infectious. We cannot say that we accept 500 or 1,000 deaths a day—it does not work like that. The rates are either going up or they are going down; that is the importance of the reproduction number.

That is why we are seeing variations. The question is, what are we trying to do with the virus? Until we get some consensus on where we are going, it will be difficult to get alignment. Now that the Brazilian variant has come in, and we have seen some of the difficulties involved in managing it—in England, they are still trying to find one of the people who tested positive, and we are seeing the difficulties of not having appropriate tracking in place—the Government might tighten the system. We do not want to undermine a whole vaccine programme because we have imported a variant.

Israel stopped all flights in and out of the country until it had vaccinated its population. Norway had a similar policy. Canada's current position is very similar to where we have gone in Scotland: all international arrivals arrive at certain airports and go into managed quarantine; people can go home to finish their quarantine after they have had two negative tests, but they must go to hotels first. We are seeing more countries go that way. The vaccine is wonderful, until we get a variant that somehow makes it not as effective. All of a sudden, that sets us back a few steps, and nobody wants to go backwards.

Donald Cameron: Thank you for that answer. You covered some of the issues that I want to address in my next question, which is about the potential for undermining any country's ability to suppress the virus. Is there any evidence so far that people are bypassing the Scottish system by flying via England, Wales or Northern Ireland, where there is a less strict regime? For instance, they may travel to Manchester or Newcastle and then up to Scotland. Is there any evidence that that is actually happening?

Mark Johnston: That is the challenge that we face with the two different policies that are in place and the loophole that effectively exists. Scotland has a blanket policy that no international travellers should come into the country without going into hotel quarantine, but what happens in practice is that, because the UK Government has a red list of countries, it is possible for people to fly in and then travel up to Scotland and isolate in their house, instead of in a hotel. The four-nations approach is quite frustrating and confusing, and it creates a big challenge for our industry.

Those issues arise not only in respect of how we administrate the policy. The UK Government has set out a road map for coming out of the restrictions. It has heavy caveats with regard to

the dates on which certain things might occur, but at least there is a road map with prescriptive triggers for each stage of coming out lockdown. However, we are already hearing that a lot of people with postcodes in Scotland are booking flights from England. Anecdotally, we are hearing from the airlines that they will potentially move their capacity down south because there is effectively no light at the end of the tunnel, or a road map, in Scotland. That presents challenges for us. As an airport, we do not manage the health side of things, but we deal with the commercial side, and those discrepancies and differences are really challenging for us.

The Convener: Have you noticed in the airports any impact on internal connections from elsewhere in the common travel area?

Mark Johnston: I cannot emphasise enough that we are currently open only for critical flights. There are lifeline flights to the Highlands and Islands, and we have connectivity with London, Belfast and Dublin. There is also some connectivity with Aberdeen for the oil industry. Essentially, however, our passenger numbers are in the low hundreds when we would normally have 40,000 or 50,000 passengers across the group. There really is not much activity. The airlines have scaled everything back—they plan six months in advance, so they are currently looking at the situation and saying, “We just don’t know what to do.” We accept that things might change and that the situation can move, but at present there is no light at the end of the tunnel for our industry in terms of knowing, from a Scottish perspective, when we can get back up and running.

The Convener: There are a couple of supplementaries from Sandra White and Emma Harper.

Sandra White: I was interested to hear Mark Johnston’s reply with regard to the different guidance from the different nations. We have a four-nations approach. It would surely be prudent, therefore, for each nation to be able to set out its guidance and the way that it wants to do things, instead of having a bunfight in which Westminster says one thing, Scotland says another thing and Wales and Northern Ireland say something else. Our approach is really about stopping the virus from spreading. Is it not prudent for the Governments of each nation to look after the people whom they represent?

The Brazilian variant is now here in Scotland, and there is evidence that people are bypassing the restrictions. Devi Sridhar mentioned that previously, when she talked about people going from Madrid to London. People are travelling to England and then moving up to Scotland by car or train, or going on a plane with other passengers, which is partly how the Brazilian variant got in. Would the proper way to go about dealing with the virus not be for each nation to decide what is best for it?

The Convener: I will take Emma Harper’s supplementary now, and then ask both witnesses to respond to both questions.

Emma Harper: My question is about vaccines and variants. I take on board what Mark Johnston said about how completely affected the airline business is. Perhaps this question is for Professor Sridhar. We will need to continue with managed quarantine, or isolation, for a while. My concern is about the new variants. We saw what happened when the Kent variant came into Dumfries and Galloway, which went from level 1 to level 4 almost overnight, just before Christmas. The effect of that was massive.

People are now asking specifically for the Pfizer, AstraZeneca or Moderna vaccine—they are choosing their vaccine based on whatever information they are getting. I say that as someone who is a vaccinator with NHS Dumfries and Galloway. I am curious about what we know about the vaccines and their effectiveness against new variants. I imagine that we need to be really careful in how we look for any virus coming into the country and manage it so that we get the levels as low as possible. My concern is that the current vaccines might not touch the new variants.

The Convener: Those two questions are slightly different—that is my mistake. Nonetheless, I would be grateful if the witnesses could deal with them both: Sandra White’s question on the different regimes and Emma Harper’s question on vaccines.

Professor Sridhar: On the first question, I think—as someone who has been an external observer for the past year—that all four nations need to work together. The reasons for that are twofold. First, we have a shared border and as long as we have a lot of traffic across that border, our efforts will be more fruitful if we try to collaborate and reach a co-ordinated agreement on how we work across all four nations than if we try to police the border. We should not be policing people’s movements any more than we need to.

Secondly, we knew from the start that two areas of society would be hit the hardest. One is travel and tourism, because of restrictions on the mobility of people. That applies to every country—passenger traffic is coming down not only because of the restrictions, but because of the virus. The pandemic has affected how people behave. Even if the airports were completely open, as they were during much of the first lockdown, the passenger numbers would be down anyway, because people shift their behaviour as they do not want to travel when there is a virus circulating.

The other area is the hospitality sector: bars, clubs and night-time live music. We always knew that the situation would be difficult for that sector. We need financial support for those sectors—we need to support aviation so that there is no loss of jobs, and we need to support hospitality. In that sense, as we move out of lockdown measures, we need to release people and get them back to work where we know that it is safe, and we need to concentrate our financial support, and Government support, on those sectors—aviation and associated travel and tourism, and hospitality—which we know will struggle because of the nature of the pandemic. That is unfortunately beyond the full control of any one nation—we need a four-nations approach, which needs to come from down south, in London.

On the second question, about variants and vaccines, we have been lucky in that the B117 variant that has taken off here is more transmissible but does not seem to reinfect people who have had Covid, and that our vaccines—we are using Pfizer and AstraZeneca—are still pretty effective against it.

As new variants emerge, we need—[*Inaudible.*]—more mutations. That is why the P1 variant is worrying: it has three different mutations in it. The question is whether people who have already had Covid will be reinfected. Is the new version so different that our immune system cannot recognise it, and our antibodies and T-cell response cannot protect against it?

There are worrying indications from South Africa and Brazil. South Africa has done tests with the new variant and found that it is reinfecting people who have had Covid previously. That means that we cannot work our way up and gain some immunity—we will get waves of the virus, because people might get the newer version. Brazil has found that some people have had two different versions of Covid at the same time, because they are so different. That is the worry. Luckily, the vaccines still seem to work pretty well against those variants. The Johnson & Johnson vaccine is working even against the South African strain; it is being rolled out in the States, and we will get some stock of it later on this year.

I will make two final points. Right now, we are on a plane of scientific uncertainty. We do not know which new variants will emerge. With more and more replication of the virus, more mutations occur. Some have a selective advantage and they continue, and some do not, so they burn out. Unfortunately, the mutations that have a selective advantage are those that can reinfect people who have already had Covid, because those that cannot do so die out, while those that can will spread.

We are gambling a little bit in terms of how much we want to permit international mobility and travel, in the hope that, with the red-list approach, we can catch some of the variants, and that nothing really bad—such as the chance that something really difficult could emerge in a variant—will happen. There is uncertainty—no scientist can say for sure—but the question is how watertight we want to be in our approach. That depends on our approach to uncertainty and how much of a risk we want to take at this point in the pandemic.

11:15

The good news is that the messenger RNA vaccines—the Pfizer and Moderna vaccines, which use that new technology—can be changed quickly. Moderna has already created a South African booster, which people in the States can get as their first vaccine. We have not yet got the Moderna vaccine—we will get it probably in May or thereabouts. The vaccines can be changed quickly, which is really positive. The issue will be the time lag, once we have the vaccine, in getting it into enough people’s arms so that we reduce the spread and any associated hospitalisations.

In a way, we do not want to be in the current position of having a vaccine but having to wait to roll it out to all the groups while leaving restrictions in place. That is where the time lag would be—the companies can redevelop the vaccine within weeks; the challenge will be in manufacturing and deploying it. We are a rich country: in Scotland, and the UK, we are all in a privileged position, but there is a time issue. If we are into buying time and slowing the spread, we will need to put the brakes on, and put in place restrictions. Nobody wants to be back under restrictions once we lift them in the next few months.

Mark Johnston: I will pass on the technical question on the effectiveness of vaccines—Devi Sridhar has given a great answer on that.

With regard to the four-nations approach, all I would say is that we want it to be simple and consistent. I do not know how we achieve that, but from a customer point of view, and from our point of view as an industry, looking at how we get out of the current situation, it is important that we have simplicity and consistency against the backdrop of the difficult decisions that need to be made just now. We would absolutely support that approach.

The Convener: I thank all our witnesses for a very useful evidence session. It has exposed some of the questions that we will want to follow up with others in order to establish some of the detail that is not entirely clear, but it has been very informative to hear about your perspectives and your practical experience on the ground. We look forward to discussing the same issues with the cabinet secretary next week.

Section 23 Report

"NHS in Scotland 2020"

11:17

The Convener: Item 2 is an evidence session on Audit Scotland's report, "NHS in Scotland 2020". I welcome the Auditor General for Scotland, Stephen Boyle, who is accompanied by Leigh Johnston, senior manager, and Eva Thomas-Tudo, senior auditor, both from Audit Scotland's performance audit and best value team. We start with a short statement from the Auditor General.

Stephen Boyle (Auditor General for Scotland): Good morning, everybody. I am delighted to be with you this morning—many thanks for inviting us to speak to the committee. Our report on the NHS in Scotland focuses on the Scottish Government and the NHS—[*Inaudible.*]—Covid-19. We also give an update on the financial and operational performance of the NHS during 2019.

The NHS has faced unprecedented challenges as a result of Covid-19. NHS staff have worked tirelessly in difficult circumstances to deal with the demands of the pandemic while maintaining access to essential services, which reflects their extraordinary commitment.

The Scottish Government had difficult decisions to make about how to prevent the NHS from becoming overwhelmed. During the first wave, non-urgent treatment and national screening programmes were paused. There are longer-term risks associated with some of those decisions, but the Government needed to create additional capacity for Covid patients. There is now a significant backlog of patients who are waiting to be seen, but the pandemic is on-going. Continuing to respond to the pandemic is resource intensive and takes priority over resuming the full range of NHS—[*Inaudible.*]

The way in which the NHS delivers its services has changed drastically, with many new approaches being established. Several large-scale initiatives, such as the Covid-19 community hubs and the widespread use of virtual appointments, together with the procurement and distribution of huge amounts of PPE and the creation of the NHS Louisa Jordan, were implemented at pace, which involved working in partnership to an extent that had not been seen before. Looking forward, stable and collaborative leadership will be required to remobilise and renew the NHS—[*Inaudible.*]

Covid-19 has not affected everybody equally. Those from our most deprived communities, and those from certain ethnic minority backgrounds, are more likely to have been hospitalised, or to have died, as a result of contracting Covid. Scotland's long-standing health inequalities need to be addressed.

The Scottish Government could have been better prepared. Planning for a pandemic had not been sufficiently prioritised, and improvements that had been identified through pandemic preparedness exercises were not all fully implemented. Covid-19 is expected to cost an extra £1.7 billion in expenditure across health and social care during 2020-21. NHS boards are being fully funded in this financial year, but there is uncertainty about the long-term financial position.

My colleagues and I are delighted to be with the committee this morning, and we will do our best to answer your questions.

The Convener: Thank you. You talked about the longer-term risks arising from decisions that were taken early on in the pandemic. You mentioned in particular people waiting for operations, and screening opportunities that were missed. Has it been possible for you to quantify those risks? It is clear that they exist; we know about delayed operations and so on. Is it possible to quantify the volume of cases that might be affected, and the level of risk that is involved?

Stephen Boyle: I will start, and then I will invite Eva Thomas-Tudo to come in, because she has done a lot of the data analysis.

The general point that we make in the report is about the need for transparency around the extent to which services have been delayed, so that patients are clear on their anticipated wait time for future access to services. The report refers to the Government's intention to pause what had been a significant programme of improvement in waiting times and, in the light of the pandemic, to move to category prioritisation. We emphasise that that needs to be done clearly so that patients understand what it means for their access to services in the future.

There are significant implications arising from the pandemic. However, the report does not assess the extent of the health implications for individual patients as a result of the pause. We emphasise that clarity is needed as to what that means for future service delivery, in order to allow the NHS, as it goes through significant remobilisation and planning, to do that in an open and transparent way.

I ask Eva Thomas-Tudo to say a bit more about what the data has shown us.

Eva Thomas-Tudo (Audit Scotland): Exhibit 5 in the report gives a good indication of the pandemic's impact on demand for, and activity in, NHS services. It shows that the number of people who are waiting for treatment, and waiting much

longer, has increased since the start of the pandemic. It also indicates that referrals to hospital care have decreased, which comes with associated risks. The likelihood is that there are not fewer people needing hospital care, so the reduction in referrals could indicate that people who would otherwise have been referred for hospital care have not been referred since the start of the pandemic. We will be looking at the longer-term impact on health outcomes as a result of that.

To give you an indication of scale, the number of referrals from all sources, including from general practitioners, was approximately 450,000 in each quarter of 2019. That number reduced to 188,000 between April and June 2020, so less than half the number of people were being referred.

The Convener: The numbers that are involved are really quite substantial.

The report also covers the issue of how far the Scottish Government was able to project the needs arising directly from the pandemic. For example, there are questions around bed capacity in hospitals, intensive-care capacity and testing capacity. Have you drawn a general conclusion as to the effectiveness of those predictions and whether more accurate predictions might have had different results?

Stephen Boyle: Again, Eva Thomas-Tudo can say a wee bit more on the capacity in hospitals. I will start by saying a little about testing capacity and what our work has found. We report in detail on some of the numbers around testing capacity. We note that by December 2020, the Government had in place an effective test and protect system in accordance with the criteria that were set by SAGE. Its capacity was such that it was able to test and trace up to the relative levels of percentages that allowed it to meet those criteria.

We did not go into as much detail on overall bed capacity. In this report, we looked to form initial assessments during the pandemic, with the clear intention, in our next report during 2021, to give much more of an update on the impact of the pandemic, what the health outcomes are beginning to look like and the extent to which public money has been well spent. Eva Thomas-Tudo may wish to say something on that analysis.

Eva Thomas-Tudo: At the start of the pandemic, intensive care capacity was increased. That is one of the main reasons why a lot of the non-urgent care was paused: to increase capacity for Covid-19 patients. That meant that the NHS was not overwhelmed during the pandemic. Intensive care capacity was increased from 173 beds to 585. At the peak in the first wave, the number of Covid-19 patients and non-Covid-19 patients in intensive care was 250. That shows that if the NHS had not increased intensive-care capacity, it would have been overwhelmed, so that decision was effective.

The Convener: I want to follow up on that, perhaps with the Auditor General in the first instance. We have seen two waves of Covid cases in hospitals, and issues have arisen as to how quickly ordinary services—elective operations, for example—have been restored as the Covid numbers have gone down. Did you take a view on that in the first wave, and have you any recommendations in relation to the current position, in which cases in hospital are—we hope—now going down again?

Stephen Boyle: I lost the sound a little bit there, convener. I think that you were asking about the detail of our work on the implications of the clinical choices that were made.

The Convener: We have heard about how routine work was set aside at the outset because of Covid. The next question is, when does the NHS return to that routine work, now that the worst peaks of Covid are behind us? Did you take a view on that in 2020, and do you have a view on it for 2021?

Stephen Boyle: You are right, convener—that certainly forms a key part of our work during 2021. In this report, we focus in particular on a couple of key points. One is our analysis of accident and emergency attendance. We saw throughout the early stage of the pandemic that attendance at A and E dropped significantly. There were risks around that for patients in all cases, in particular regarding acute instances of heart disease, stroke and other illnesses that might not have been detected at an A and E presentation as they might otherwise have been.

We tracked that attendance during the year, and we report that the NHS is open campaign resulted in a growth in A and E attendance, but the numbers are not yet back to previous levels. Attendance dropped away again in the autumn, during the second wave, and there is still some nervousness among the public about what it might mean if they were to engage with medical services. An important role for the NHS is to continue to emphasise the availability of its services.

We also looked at the early stages of the pandemic, and we report on the pausing of the screening programmes and some of the clinical risks that may have been involved in those decisions. Those decisions were taken of necessity, as Eva Thomas-Tudo mentioned, in order to ensure that the NHS was not overwhelmed. Undoubtedly, however, what we are not seeing, and what we will continue to track

through our work, is what that means for clinical outcomes as we move forward. We will pick that up in our report later this year.

David Torrance: Have you seen any reports that describe and explain the rapid responses to address the threat of the pandemic that could be used for future learning?

11:30

Stephen Boyle: Future learning is a key theme in our report. We have undoubtedly seen innovation during the pandemic, in particular regarding the scale of virtual consultations. We recommend that, as the NHS remobilises, it takes a view about what that means and the place of such innovations in the future delivery of health services in Scotland.

We draw on the presence of the community assessment hubs and their rapid introduction, with regard to where they fit in the future model and what that means for NHS services. As the committee will know—we have seen your own reports on this—Audit Scotland has, for many years, been calling for a review of the sustainability of health and care services in Scotland. In the past few weeks, the "Independent Review of Adult Social Care in Scotland" report was published, so there is a great deal of material available on what will influence the remobilisation and the future of health and care services.

We are mindful of all that activity, and we place great emphasis on closely monitoring what that means for the future plan for, and remobilisation of, health and care services across the country.

David Torrance: You have partially answered my next question. What elements of the new structures should be retained?

Stephen Boyle: I am mindful of my responsibilities, one of which is not to comment on policy matters. Ultimately, it will be for Government to determine the future establishment and structures of health and care services. As I said, there is much comment, and much opportunity.

In Audit Scotland's work, especially in recent years, we have commented on the pace of integration of health and care services and the sustainability of the current model, which was designed—as we know—for an era in which there was a much greater focus on the presence of large hospitals and people receiving health services in large—[*Inaudible.*]—settings. In recent times, there has been an increasing focus on the provision of care in more homely settings, closer to people's homes, and more preventative medicine. All those factors will be taken into consideration—[*Inaudible.*]—and what that looks like.

David Torrance: Are there any risks or unintended consequences associated with any of the new ways of working, such as the new clinical triage arrangements?

Stephen Boyle: We have been clear about that. I had a similar conversation with the Public Audit and Post-legislative Scrutiny Committee last week about what some of those innovations might mean. In particular, we discussed the rapid growth in the use of virtual consultations. Over the summer and during lockdown, of necessity, the number of such consultations has grown exponentially; in our report, we use the figure of 600,000 virtual consultations. However, that approach might not suit everybody.

To be clear, we are not health professionals, and we do not know—which is why we think that there is a need for analysis alongside that rapid change—whether there are any unintended consequences of that shift, and whether anything would be lost, either as a result of people having restricted access to technology, which may prevent their ability to access services, or because face-to-face consultation provides a better interaction for both the clinician and the patient. All those things need to be considered, as we have moved at such pace to implement changes to the way in which health and social care services are delivered. We expect that to be factored into the thinking and analysis that takes place once the pandemic has eased and we are thinking about what the future might mean.

Donald Cameron: Good morning. I turn to the question of the future, which you have already touched on in discussing the growing backlog and the difficulties that we will face with people who have had treatment delayed or diagnoses missed. What measures do you think should be used to monitor the longer-term effects of delayed treatment or missed diagnosis?

Stephen Boyle: I will start, and then I will invite my colleague Leigh Johnston to come in, as she has done much of our thinking and analysis on remobilisation.

In recent years, there has been much focus in the NHS on reducing waiting times, and we have seen significant investment in that area. However, with the decision that was taken to pause that and to prioritise treatment on a clinical basis, there is a real need for important thinking to be done alongside the remobilisation in order to provide clarity around the investment in longer-term outcomes. Clarity is needed on what that means for all of us, and all the metrics that we would want to measure regarding that very significant investment. I know that the committee has a keen interest in the fact that around half the entire Scottish budget is now invested in health and care services, and there is a need for clarity alongside

that with regard to what we are achieving as a country.

As we move forward, not just in implementing the remobilisation of the NHS, but in thinking about its longer-term future and structures, we need to ensure that we, as a country, are clear about what we want to achieve for the very significant investment that we have made.

I will pause there and invite Leigh Johnston to say a bit about what we have seen in some of the material on remobilisation that we looked at.

Leigh Johnston (Audit Scotland): As we say clearly in our report, we make recommendations for the Scottish Government and NHS boards around some of the things that have been discussed today, and the need to take action to meet the needs of those whose access to healthcare has been reduced as a result of the pandemic, while also monitoring the long-term impact of that on health outcomes. As we have discussed, we recommend the publication of data on performance against the clinical prioritisation categories that have been introduced in order to measure the waiting times and how long people are waiting for treatment.

It is also important to highlight that Public Health Scotland has a key role in that regard through its work around developing different indicators and, in particular, its focus on addressing the needs of the people in our communities who have the poorest outcomes. I know that the data teams in Public Health Scotland are looking at how we expand the range of indicators that are available to look at some of the outcomes and impacts as we move forward.

Donald Cameron: Thank you for those answers. With regard to monitoring, are you aware of any health board that is planning to mitigate the delays in treatment in some way? Have you been advised of the ways in which health boards are thinking about how to deal with that, whether by increasing hospice provision, providing support for people with a terminal illness, prioritising those who need tests and so on?

Leigh Johnston: We have not looked at any of that in detail. We have to acknowledge that health boards are still dealing with the on-going demands of the pandemic. We are still in the second wave—we know that cases, and hospital admissions, are dropping now, but at the time that we published our report, we were right in the middle of the second wave of the pandemic. Nevertheless, in our next report on the NHS in 2021, we plan to look at the longer-term implications, the new ways of working that are being implemented and how health boards are dealing with the impact of the pandemic on their communities.

Eva Thomas-Tudo: As Leigh Johnston mentioned, the Scottish Government introduced the clinical prioritisation framework, which is intended to manage the current backlog in the best way possible. People are being treated based on their clinical prioritisation level, so those whose cases are most urgent will be seen first, and those who can safely wait longer to be seen will have to wait much longer. That is how boards are currently dealing with the limits on capacity. As Leigh Johnston said, we will have to wait and see what the plan is, post pandemic, for how to get on top of the significant number of patients who are waiting.

Stephen Boyle: In addition, through our work, we will follow the implementation of the Government's winter preparedness plan, which was published in October last year. It begins to explore options around tackling the backlog and the extent to which the NHS Louisa Jordan and the Golden Jubilee hospital, and even the private sector, might be available to support some of the backlog reduction. As Leigh Johnston mentioned, we will pick that up in our 2021 report.

Donald Cameron: I am glad to hear those responses. I understand that the priority over the past couple of months has been dealing with Covid, but I feel that, as we look forward, the backlog, along with remobilisation, will be one of the biggest public policy challenges that any Government is facing. Therefore, I am pleased to hear that Audit Scotland will be scrutinising that.

Lastly, I turn to the issue of health inequality. There has been a lot of evidence that the pandemic has widened health inequality, especially among deprived and ethnic minority communities. Are you aware of any emerging policy to mitigate the widening of that inequality, in particular with regard to the vaccination programme? For example, have you looked at the issue of widening inequality as a result of vaccine hesitancy?

Stephen Boyle: I will invite Leigh Johnston to comment in a moment. We were struck—others have commented on this elsewhere—by the disparity, and the extent to which the effects of the Covid-19 pandemic have not been equally felt. That is borne out by some of the statistics, in particular the stark difference in the implications for our most and least deprived communities, as well as in the extent to which the pandemic has disproportionately affected our black, Asian and minority ethnic communities.

Government policy makers have some real thinking to do about what that means, how we can take the necessary steps to reduce those inequalities and the extent to which we can learn from this pandemic for future pandemics. Of course, we do not know whether Covid is a once-in-a-century pandemic, or whether there will be a

series of pandemics for which we will need to take the necessary action and incorporate that into our lives.

With regard to the vaccine programme, we have not done much work on that yet. There are opportunities for us to do so as we reflect on the success of what will—we hope—be a roll-out across the population in time for us to capture that analysis for our overview report in 2021. That will be a key part of our thinking.

Leigh Johnston might wish to say more about that.

Leigh Johnston: As we have discussed, the pandemic has shone a light on what—as the committee will know—are long-standing issues in Scotland around health inequalities and socioeconomic inequality. Back in September 2020, the Scottish Government established an expert group to look at the impact of Covid-19 on ethnic minorities in particular. That group published two different reports, which contained various recommendations for improvements around data and the evidence on inequalities in health in those communities.

As I said previously, Public Health Scotland has a huge role to play in that regard. It came into being right at the start of the pandemic, and it has been at the forefront of the response, generating some of the data that we have on various issues. However, it has not been able to push forward with what it was originally set up to do, which was to take a whole-system approach in starting to look at health inequalities and the poor outcomes that exist in some of our more vulnerable communities.

Emma Harper: Good morning. I have a couple of questions on pandemic preparedness and planning. Your report states:

> "Not all actions from previous pandemic preparedness exercises were fully implemented".

The exercises were Silver Swan, Cygnus and Iris. I am looking at paragraphs 43, 44 and 45 of the report, and other paragraphs. The report goes on to say:

> "the Scottish Government did not include an influenza pandemic as a standalone risk in its corporate or health and social care risk registers."

From the report, it looks as though issues were recognised that could have been taken forward. Do we know why there was a lack of preparedness or action, and why some of the recommendations from those exercises were not taken forward?

11:45

Stephen Boyle: You are right—in our report, we draw the conclusion that there were opportunities, following those exercises, for the Government and the NHS to be better prepared for a pandemic. To answer your specific question, we also report that a pandemic was a known risk in the Government's thinking. In addition, the implications of a pandemic were identified as being very severe. What we did not see in our analysis was evidence that a pandemic featured routinely as a risk that was being actively managed, in spite of the extent of the implications of the pandemic that we have now seen.

Other risks featured prominently on the Government's risk register at the time, but the pandemic implications did not. I do not have a direct answer to your question with regard to why that was the case. Although we know that there was visibility of the risk in Government, and there were working groups and exercises, as we set out in the report, we do not have an answer in respect of the extent to which the risk was escalated to the top of a corporate risk register. The committee may wish to explore that further directly with the Government.

Emma Harper: Do you think that planning would have made a difference—for example, in access to PPE and how quickly the system for that got up and running? Initially, care homes did not have access to sufficient PPE, or even appropriate training in its use. I am thinking about healthcare professionals participating in training and fit testing in respect of specialist PPE, such as face masks for aerosol-generating procedures. Have you been able to ascertain what difference planning in that regard would have made in the response to the pandemic?

Stephen Boyle: At paragraph 44 of the report, we highlight the three themes in the recommendations that arose from the three exercises, which came to fruition during the pandemic: the extent to which our care homes were prepared; clarity around roles and responsibilities; and—as you mentioned—the use and availability of PPE.

We have not done a detailed analysis of the correlation between the extent to which PPE was or was not available right at the start of the pandemic and what that meant for health and care workers. Instead, we have drawn on the published findings of surveys from the British Medical Association and the Royal College of Nursing, and on what some of our health boards were saying right at the start of the pandemic about the availability of PPE and the need to purchase it directly.

We drew the conclusion that, given the unprecedented exponential growth in the use of PPE, from under 100,000 items in a typical week during pre-pandemic times to more than 24 million items per week, there might have been

opportunities for us to respond immediately and to be better prepared for the pandemic. What we have not previously done, but will continue to do through our work and the work of others, is look at and monitor use and availability of PPE. The committee might be interested to know that we will publish further work this year on the extent of the use of contracts for PPE, and we will begin to explore some of the value-for-money arrangements that Scotland implemented.

Scotland's arrangements are now well in place. We have seen, through the work of NHS National Services Scotland, that there is sufficient PPE to support the needs not just in the NHS but in our health and social care settings. As we note in the report, the arrangement for the use of PPE in social care settings extends through to the summer of this year.

Emma Harper: I am sure that everyone has learned so much about preparedness for future pandemics, whether they are coronavirus or flu-type pandemics.

You suggest in your report that, as a priority, pandemic guidance should be updated. How soon should that be done? What should the guidance include? I am sure that a lot of it can be taken from the experiences that we have had in the past year. I am sure that everyone will agree that we started at a level at which we needed to rapidly assimilate and implement measures very quickly in order to tackle the pandemic.

Stephen Boyle: We agree—we think that an update needs to happen very quickly. We set out some of the chronology of the guidance, which dates back to around 10 years ago. The original process of updating that had begun, and there had been consultation on the guidance for social care settings in the event of a pandemic, but it had not been published.

We do not think that there is any real value in publishing it now, given that so much has changed and so much learning has taken place in the past year. That learning needs to be incorporated, so that we can learn from users and staff in health and social care settings. It should be incorporated into what will inevitably be a fairly iterative document, but which will not—to the extent to which we were preparing for and thinking about pandemics previously—borrow our thinking from 10 years ago, given that so much has happened in the past year. That guidance should be produced quickly so that if there are more pandemics, we are—as you say—better prepared and able to respond next time round.

Sandra White: Good morning, everyone—it is still morning at this time. I want to ask about the remobilisation and staffing of the health service. I think that you have answered some of my questions—if you have, you can say so. I thank you for your report; perhaps some of the answers to my questions will be in your 2021 report.

You highlighted in your report the issue of waiting times and the fact that some elective surgery has been put back for a while. However, you went on to say:

> "The Scottish Government is committed to rebuilding the NHS differently",

and you gave some examples, including provision of more care nearer home and recognition of the interdependencies between health and social care services. As your report says, there is a lot of work to be done in that regard. Is the Scottish Government being too ambitious in trying to deal with the backlog at this time while also

> "rebuilding the NHS differently",

as you said in your report?

Stephen Boyle: There is a huge programme in front of the Government in terms of continuing to deal with the pandemic, rolling out the vaccination programme, recovering the backlog of services and assessing the extent of the clinical risk that remains within that. Alongside that is continuation of the programme of health and social care integration and all the matters that you talked about, including provision of care and treatment closer to home and a focus on preventative services as opposed to the large acute hospital setting model. All that needs to be tackled, and we empathise with the NHS and with Government in respect of the need to take such decisions.

Audit Scotland will continue to monitor and track that, and to look at the extent to which the Government is taking steps to implement the ambition that it has set out in its remobilisation, renewal and recovery programme. That is a key part of our work.

I agree that it is not a straightforward undertaking. We recognise that, if that was the case, many of the challenges that we set out in the report would have been dealt with many years ago. Nonetheless, it will remain a key part of our work and commentary.

Sandra White: In your opinion, what priorities should the Scottish Government put forward for the recovery and reshaping of the health service?

Stephen Boyle: I am mindful that it is ultimately for policy makers to decide what the priorities will be, to the extent that there is consensus on that. Again, I have signalled through our forward work programme that we will continue to monitor progress on health and social care integration and on how, as we change the way in which we think about health and social care and move away from the large hospital environment to care in more

homely settings closer to home, that is all factored in.

We have stated that we will look closely at the extent to which progress is made on tackling inequalities in the country, with reference to progress on reporting on that through the national performance framework. That all features in the work that we will take forward over the next year and beyond.

Sandra White: When we held our inquiry, we heard from the general public that they preferred services being provided closer to home to having to go to the big hospitals. That gels with what you said.

We are talking about workforce planning reform. Have you been able to identify any specifics in relation to that particular aspect?

Stephen Boyle: In paragraph 57—

Sandra White: I will write that down.

Stephen Boyle: We refer in that paragraph to the wider thinking about what that plan means for the health and social care workforce. We are following closely what might come of the Feeley report on the independent review of adult social care, and whether that signals a significant change for the way in which health and care services are structured. In addition, we will look at what that will mean for the workforce.

We think that there is a real need for a clear plan for the integrated health and social care workforce and to ensure that it is flexed and monitored as necessary in order to deliver on the ambitions for health and social care integration. Again, that features prominently in our thinking and our work as we move forward.

Sandra White: My last question is about the staff who have come through the pandemic. Obviously, they have faced a lot of pressure and stress. Have you identified any long-term planning to support those staff, who have been through such a traumatic time?

Stephen Boyle: We recognise, of course, that the period of the pandemic has been an incredibly challenging and difficult one for all our health and social care workers. My colleagues may wish to say a bit more about the extent to which the wellbeing of health and care workers has been supported. In our report, we said that we will continue to track that.

I do not think that we know yet what the long-term implications might be of the stress and anxiety—even the trauma—of having to deal with not just one wave, but two waves, of a pandemic. I think that it will be some time yet before the NHS and the Government are able to form an assessment of what the implications might be.

Eva Thomas-Tudo may wish to say a bit more about what we have seen and the extent of the support that has been provided so far.

Eva Thomas-Tudo: In our report, we mentioned the launch of the national wellbeing hub website. As we have seen, that has had quite a good response; around 50,000 people had visited the website by December. There is also a helpline and a wellbeing champions network, which were launched during the pandemic. We recommended that

> "The Scottish Government and NHS boards should monitor and report publicly on the effectiveness of the measures"

that have been put in place to support staff wellbeing, in order to ensure that

> "sufficient progress is being made."

Brian Whittle: Good morning to the panel. It is still morning—just.

To follow on from Sandra White's questions, it has come to my attention and the attention of the committee that Covid has highlighted where the weaknesses are in the system and the need to reform and renew the way in which the NHS delivers its services. How could a renewed look at the integrated workforce plan better incorporate new priorities for the NHS, based on staff engagement? How do we ensure that engagement with staff is to the fore in any kind of reform?

12:00

Stephen Boyle: That is an important point. Ultimately, given the scale on which staff are represented in delivery of services, and given the cost of the NHS, engagement with staff and their representative bodies is an essential component of an effective workforce plan that connects with the overall strategy, and the strategy of renewal and remobilisation. I am not sure that we have the detail on the extent to which those conversations have taken place.

Currently, all the activity going on is focused on preventing the NHS from becoming overwhelmed, delivering the vaccination programme, and seeing us through the next wave. I anticipate that, over the summer, the NHS will move significantly into thinking about what renewal and remobilisation will look like. Nevertheless, we agree that staff engagement is an essential component of a well-structured and well-developed workforce plan.

Brian Whittle: I will amalgamate two questions, if I can. Earlier, you talked about the preparedness exercises that had been undertaken and the lack of preparedness for a pandemic. I will offer an analogy. We all know that an asteroid is going to hit the earth—you just hope that it is not going to happen on your watch. That is maybe similar to what happened with the Government. We knew

that, somewhere down the line, there was going to be a viral infection such as Covid; the Government just hoped that that would not happen on its watch.

Moving on from that, the question is: how should front-line staff be involved in future pandemic planning in order to ensure that recommendations are enacted?

Stephen Boyle: The fact that there were three pandemic preparedness exercises in the five years before 2020 demonstrates that a pandemic was part of the Government's thinking and activity with regard to what risks might be coming down the line. It was not presenting as an issue in the same way as some of the other risks that Government faces from day to day. Nonetheless, our analysis suggests that, if the recommendations that came from those exercises had been implemented, the Government might have been better prepared to deal with the situation that presented itself in March 2020. There were recommendations around the extent to which care homes were prepared and the use and availability of PPE. We effectively drew the conclusion that there were opportunities therein to be better prepared.

We absolutely agree that the experience that NHS and social care workers have gone through needs to be captured and reflected in all our thinking, preparedness and planning for the future delivery of health and social care services. It is really important for the future that staff are engaged and have the opportunity to share their experiences.

Brian Whittle: I am simply musing, or wondering, about the severe acute respiratory syndrome—SARS—outbreak in 2003, when there were headlines that said that 50,000 deaths were likely. That did not come to pass. I wonder whether that coloured judgment prior to the Covid pandemic.

How should the Government engage the public in the new priorities? As a caveat to that, I always think, with regard to engaging with the public, that "You don't know what you don't know." Perhaps some sort of information would need to be provided prior to that engagement.

Stephen Boyle: On your first question on SARS, or MERS—middle east respiratory syndrome—it is true that there had been pandemic events during the 21st century. However, they were predominantly in Asia and did not reach the UK, so I do not know whether that experience led to any particular thinking in Scotland. I am not able to draw any conclusions about that.

What we have seen with regard to the Scottish Government's preparedness is that most of the thinking was based on a potential flu pandemic scenario. As significant as SARS may have been, on the question whether it led to our being less prepared than we might have been, we point to the fact that there were recommendations from the reports that had not been fully implemented, and we draw the conclusion that we may have been better prepared if they had been.

On your second question, about options for engaging the public, I am maybe not best placed to say how that could best be done. We recognise recent innovations, such as citizens panels, as an opportunity to engage the public in the development and implementation of new policy ideas, having seen some of the reporting from those panels on climate change and so forth. I am sure that members will be better versed than I am in how best to do that.

I agree with the fundamental point on changing the nature of health and social care services as fundamentally as has been indicated through the plans for renewal and remobilisation. It is clear that we all care deeply about what those services mean for ourselves and our families, and citizens and the public would want to be actively engaged in developments in that regard.

Brian Whittle: I have one final question, which is about the staff turnover at executive level. You noted in the report that high turnover at that level has been pretty much a feature in recent years. Does that have the potential to destabilise any plans for the future? Are there any reflections on, or insights into, what might happen in that respect?

Stephen Boyle: In the report, we drew the clear conclusion that the NHS needs stable leadership. We pointed to what has been quite a surprising volume of change at senior executive and board chair level in recent times. Even turnover in senior positions in the Scottish Government health and social care department itself has been high.

We agree that there is a need for stable leadership in order to deliver the change that is coming after the pandemic and to steer us through the pandemic, at both national and local levels. It is important that Government is thinking about the extent to which it manages that change and supports its new leaders in those positions so that they are better able to discharge the significant responsibilities that they have.

David Stewart: Good afternoon to the Auditor General and our other witnesses. Auditor General, I was struck by one aspect of your report. It states that

"It is not yet clear … how the pandemic will develop over time and what level of spending will be required to respond",

or

"what additional funding will be made available through Barnett consequentials"

for 2021.

My first question is on additional Covid spending for boards. As you will be well aware, the funding mechanism for that was not the normal NHS Scotland resource allocation committee funding formula. The funding was given as required, very quickly, in an emergency situation, and it seemed to be demand led.

Is it too early for you to assess the effectiveness of that different formula for spending? If not, can you say whether that will have implications for the use of the NRAC formula in the future? I accept that that is a policy question. Nonetheless, can you say, in your role as Auditor General, whether there is a better mechanism for that funding that would be more effective for health boards?

Stephen Boyle: There are a number of facets to that. A key part of our work during 2021 involves what we refer to as "following the pandemic pound", which is about making judgments through our work at national level, and through local auditors' annual audits of NHS boards and integration joint boards. That involves looking at the flow of money and how well it has been spent.

You are right that it will be for policy makers to determine what that means for any changes in the NRAC formula and the wider redistribution of health funding. However, we will think about that carefully in our work and reporting, and in particular what it means for our NHS overview report in 2021.

You are also right that it has been a very unusual year. Typically, until now—as the committee will know—individual NHS boards have been facing financial challenges and using brokerage facilities from Government to support their financial position. However, during the pandemic, Government took a clear position that every body would be fully funded to deliver services on—as you say—a demand basis. Whether that position holds and becomes the new normal or whether we revert to the three-year medium-term plan, with its associated savings and so forth, is something that we will continue to track in 2021.

David Stewart: Thank you—that is very helpful. I move on to Barnett consequentials. Are you convinced that over the period that we are talking about, with regard to both Covid and non-Covid spending, the Scottish Government passed on all the additional Barnett consequentials to the NHS and social care in Scotland?

Stephen Boyle: Eva Thomas-Tudo is probably best placed to answer that. Our understanding is that Barnett consequentials have consistently flowed through to NHS services in Scotland. We draw out a couple of figures in the report. The projected additional spend requirement arising from the pandemic—the forecast spend—was £1.7 billion, but £2.5 billion was available in the round to support that funding. We do not think that there has been a shortfall in funding for delivery of services. Going back to your earlier question, I note that funding is being supplied on a demand basis, as opposed to money being held back.

I invite colleagues to say whether there is an updated understanding on that point.

Eva Thomas-Tudo: It is a moving picture. In the report, we stated what the situation was at that point in time. Since then, further consequentials have been confirmed. In September, the Scottish Government confirmed that any consequentials based on spend for health in England would be passed on for health in Scotland. So far, £2.9 billion has been allocated for the health portfolio, and £3.7 billion of health resource consequentials have been received.

For 2021-22, we know that the UK Government has so far confirmed £719 million in consequentials, but that relates to quite a limited range of spending, which includes PPE and test and trace. The Government expects further funding to be announced in due course. At present, the Scottish Government has initially committed to £869 million in Covid funding for next year, which is the £719 million that has been confirmed by the UK Government and an additional £150 million to reflect the expectation that further funding will be made available.

David Stewart: There are a lot of telephone-book numbers being thrown around. I suppose that my point is that, although there might appear to be a gap, there will be a lag in spending—the Government will have plans, so that money will not be fully spent at present. In simple terms, is that the point that you are making?

Eva Thomas-Tudo: Yes, essentially.

David Stewart: Right—thank you.

I move on to another area. Auditor General, do you foresee any challenges in the audit of additional spending in the current financial year for both health and social care? If so, how do you intend to approach the audit in future years?

Stephen Boyle: The scale of the additional spending that has taken place is stark. We have done some initial analysis on where that money has been spent. As we say at paragraph 62, it has been spent on PPE, implementation of a Covid testing regime and additional bed capacity. We will continue to monitor and track where the money is being spent.

12:15

NHS boards' financial reporting arrangements have largely remained consistent. The position will be clear from our work, which is built up through the audit of individual health boards and consolidated through to the NHS. We have the mechanisms in place, and the audits have continued during 2020 and will continue beyond that, so we will monitor the situation in our usual way.

What is important in our work is that, given the scale of the additional moneys for the provision of health and care services and more widely—we have seen some of the economic support arrangements that have been put in place—we ensure that it is clear how well those moneys have been spent. We have a detailed programme of work that will enable us to report on that in 2021.

David Stewart: I come to my final question. We are looking at a general remobilisation and reshaping of the NHS in the future. We have existing performance standards that are well known and understood. Should those standards be changed in the light of the massive impact of the pandemic? Alternatively, is it the case that the structure is right and the standards simply need to be fine tuned?

Stephen Boyle: The extent to which those measures are measuring the right things and influencing behaviour is an interesting point. It is ultimately for policy makers and Government to decide whether the performance measures are sufficient to measure outcomes, as distinct from inputs and outputs, from the use of public money.

Moving beyond those points, I go back to our conversation earlier this morning. If we are spending 50 per cent of the Scottish budget on health, we can reasonably track what that means for outcomes. For us, that is an important point—[*Inaudible.*]—in policy terms. From an audit perspective, it enables us to say publicly what is being delivered, in the widest sense, for the investment of public money. That work is focused much more on outcomes than it has been in recent times.

Emma Harper: I have a question about new indicators and how we measure outcomes. I am thinking about how we look at existing standards and whether they should be replaced with the national performance framework outcomes, for instance.

In the past year, Covid has had a massive impact on health and social care, especially acute NHS care and primary care. It has also affected care homes, with all the testing of care workers that is going on. In addition, there are various models of care homes. For example, there are council-run homes and private homes, and some are small while others are medium sized. Some homes that look after older persons are run by large corporations. When we are trying to assess all those aspects and audit the performance, should we be looking at replacing existing standards with national performance framework outcomes?

Stephen Boyle: It is a complex picture, and you are right that the wide range and scale of entities that are delivering health and social care is part of the thinking. We will be tracking in particular—I am sure that the committee will do this, too—what happens on the back of the independent review of social care and what that means for any changes to structure.

In the simplest sense, indicators are set that are meaningful and drive the right behaviours. Fundamentally, they are based on outcomes, so that we can all track what we are getting for our significant investment.

With regard to your question about replacing the standards, it is not necessarily about choosing between one system and the other, or ditching all the current indicators and moving to an entirely new set. In the report, we refer to the importance of transparency in the context of the backlog and the remobilisation of services, so that all of us who need to access health and social care services can be clear as to when we are likely to be able to do so.

All of it matters. More fundamentally, we need to look at outcomes so that we can track progress accordingly. It is for policy makers to come up with a suite of indicators that allows Government, parliamentarians and the public to get a more rounded sense of what we are getting for our significant investment.

Emma Harper: Is Audit Scotland well prepared to audit services for best value and quality on the basis of outcomes? Is it advising Government on appropriate measures and evaluation strategies?

Stephen Boyle: I am clear that we would not stray into the territory of advising Government. We are independent of Government in our work.

Our work on best value is expanding. The statutory duty of best value is on local government bodies. Through the work of the Accounts Commission, we are developing an expanded approach to our work in that regard and exploring it in the context of integrated health authorities. We will be rolling that out in the next year or so, in order that we can comment in our work on the delivery of social care services and how that duty is being applied in the widest sense.

We keep our methodologies under regular review and we think about how to ensure that we are operating to best effect. Outcomes remain a

key part of our thinking, and they will continue to be so throughout delivery of our work programme.

The Convener: I have a final question on the final section of your report, in which you touch on hospital-acquired infections and antibiotic resistance. The WHO has expressed concerns about antibiotic resistance worldwide in the context of the current pandemic and any future pandemics. Do you believe that the measures that are in place to address and monitor those risks are adequate? If not, what should be done about that?

Stephen Boyle: I will pass that question to Eva Thomas-Tudo, as she has done much of the analysis on that point.

Eva Thomas-Tudo: We have not done a lot of detailed analysis on the measures that are used to monitor healthcare-acquired infections. We have essentially used the antimicrobial resistance and healthcare-associated infection service data for that analysis, so ARHAI would be better placed to say what is being done in that regard.

The Convener: I thank you all for your evidence today. Your input is much appreciated. The Health and Sport Committee's on-going engagement with Audit Scotland has, from our side, been valuable over the past five years, and we have seen some of our recommendations being reflected in the priorities that Audit Scotland has set. It has been a fruitful collaboration, and long may it continue.

We will move into private session on a different platform.

12:23

Meeting continued in private until 12:38.

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