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Health, Social Care and Sport Committee

Tuesday 3 June 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 3 June 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
17th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Committee Substitute)
Daniel Kleinberg (Scottish Government)
Claire Lamza (Mental Welfare Commission for Scotland)
Suzanne McGuinness (Mental Welfare Commission for Scotland)
Dr Jim McMenamin (Public Health Scotland)
Julie Paterson (Mental Welfare Commission for Scotland)
Professor Sir Gregor Smith (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 3 June 2025

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 17th meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies from Brian Whittle and Elena Whitham. Stephanie Callaghan joins us online as a substitute.

The first item on our agenda is the committee's agreement to take items 5, 6 and 7 in private. Are members agreed?

Members *indicated agreement.*

Pandemic Preparedness

09:15

The Convener: The next item on our agenda is an evidence session on pandemic preparedness. I welcome Professor Sir Gregor Smith, chief medical officer for Scotland; Daniel Kleinberg, deputy director, population health resilience and protection division, Scottish Government; and Dr Jim McMenamin, interim director of clinical and protecting health, Public Health Scotland.

We will move straight to questions.

Emma Harper (South Scotland) (SNP): We are a few years down the line from the Covid pandemic, and I am sure that we all have personal experiences and remember things about it, including what could have happened or what could have been done. During the pandemic, as a registered nurse, I was giving vaccines as well as being an MSP. I am therefore interested to know the detail of any progress that has been made in implementing the United Kingdom Covid-19 inquiry's module 1 recommendations that the emergency preparedness and resilience structures should be simplified. I see that Sir Gregor is nodding.

Professor Sir Gregor Smith (Scottish Government): I will begin, and my colleagues will add to what I say. As you said, we are now—unbelievably—just over five years on from the moment when a pandemic was declared and the world changed for all of us as we sought to combat the effects of Covid-19. You are right that there has been substantial learning since that time, during the pandemic response and in the period afterwards, through statutory inquiries, which you have referred to, and other sources. It is important to reference those other sources of learning, starting with the production of the four UK CMOs' technical report and the substantial body of evidence within that as to how, technically, we should respond to future threats when, inevitably, they arise.

Moving on from that, the standing committee on pandemic preparedness produced a substantial report with recommendations that have begun to be implemented. In addition, the UK public inquiry has published its module 1 recommendations. I will turn to my colleague Daniel Kleinberg in a second, as he can speak about some of the work that has been taken forward in relation to that.

At a UK level, extensive work has been done in examining the technical aspects of the response that will be necessary when, inevitably, a future pandemic arises. We should think about that as "when" rather than "if", because, whether it is in the next year, five years or 20 years, we will continue to encounter pathogens with pandemic potential. During this hearing, we can speak a little about the types of pathogen that are most likely to cause that threat.

At the moment, an update to the respiratory care action plan is in preparation, looking at the broad range of respiratory pathogens that may have pandemic potential, on which we may need to act and provide some sort of technical response to. Work continues on that at a UK level, with Scotland contributing in a technical and a policy sense.

In the Scottish context, the standing committee has probably provided one of the most important pieces of work in recent times. It has developed recommendations for us to consider and take forward, not least on the formation of a Scottish pandemic sciences partnership. Daniel Kleinberg can give us an update on that.

Daniel Kleinberg (Scottish Government): Before I talk about the standing committee, it would be good if I could start with the question, which was specifically on the Hallett inquiry's module 1 recommendations.

The Scottish Government has welcomed, in full or in principle, all 10 of the Hallett recommendations. However, some of them fall to the UK Government—for example, there are recommendations about simplified structures for civil contingencies and the lead Government department model in the UK, on which we are working closely with the UK Government. We will wait to see where it goes with that.

For the most part, Hallett talked about the need for things such as simplified structures and how to go about that, which is something that I recognise. Kate Forbes, as Deputy First Minister, has written to Baroness Hallett to say that the Scottish Government will make full responses to each recommendation by the end of the year or, in some cases, sooner.

As Gregor Smith alluded to, we are already seeing the beginnings of simplified structures, which tend to relate to the wider contingency response. I am interested specifically in pandemics, but pandemics do similar things to some of the other big risks that we face. The pandemic diseases capabilities board, a UK structure in which we fully take part, has begun to look specifically at future pandemic preparedness. Gregor spoke about the respiratory action plan that is being prepared and drafted, which will be the basis of a more specific response to future respiratory threat.

Hallett said that too much emphasis was placed on a pandemic flu plan—a point that I think is uncontroversial and accepted by everybody. At a UK level, we have already looked at different types of pandemic threat. There is now a draft respiratory action plan, which will be followed up with plans on other threats such as sexually transmitted diseases and other sources of disease—it is a much broader-based planning approach.

The response to module 1 is well under way and the formal response from the Government will follow later in the year.

Emma Harper: I know that there are complexities around planning, whether that is for flu or other potential disease pathogens. We have talked about various reports, such as the module 1 report, the respiratory action plan and the one that recommended the Scottish pandemic sciences partnership. Work is under way, but are you confident that that is a process of simplification?

Daniel Kleinberg: Yes, although it is still a complex environment. I do not want to give false assurance that it is all straightforward, because pandemics are such complex things to respond to. In Scotland, there is now a single-level ministerial group that is looking at pandemic preparation and capabilities assessments. That group first met this January and it will next meet tomorrow. There is an improving position in the UK as well. So, we have mapped out the governance better than we did in the past. Having that specific group on pandemics will add to the number of groups, but it will potentially allow for much greater specificity in thinking about and responding to the risk.

Professor Sir Gregor Smith: I agree with Daniel Kleinberg's assessment. There is an improving situation in an area that is necessarily complex because of the wide range of potential threats that could be faced in this space. However, sorting out the governance at the centre of all this has been a tremendous step forward.

A co-ordinating centre that involves the Scottish Government, academia, the public health agencies and industry is being set up to co-ordinate the science that sits around a future pandemic response. That is a big step forward for us. It is beginning to find its feet. I see elements of that forming around us just now.

David Torrance (Kirkcaldy) (SNP): Good morning, everyone. My question is about risk assessment and future planning. Further to the findings of the UK Covid inquiry's module 1 report, what changes, if any, have been made to the risk assessment process in Scotland to take better account of the specific needs of the Scottish population and who might be vulnerable?

Daniel Kleinberg: In effect, we are managing two risks: emerging infectious diseases and full-scale pandemic diseases. Both of those are described at a UK level in the national risk register, which is a public-facing document. To give you a sense of it, that assesses the risk of a future pandemic occurring in the next five years as being between 5 and 25 per cent. That will be catastrophic if it occurs, and the risk of it doing so is fairly probable.

The methodology that lies behind that is constantly under review—it is being looked at again at the moment. That informs how we work with the Scottish preparedness community. There has previously been a Scottish risk assessment, but, in effect, the risk of a pandemic is a global risk, so the articulation of that and the methodology are very similar in both cases. It is how you respond that changes and is local.

Professor Sir Gregor Smith: Jim McMenamin might want to add to what I have to say. Across the UK, there is constant horizon scanning of emerging pathogens or disease patterns through the global sharing of data and surveillance mechanisms. That is a really important point. The strength of global surveillance is absolutely key in all of this. We might want to go into the role of the World Health Organization in that regard at some point in the meeting.

That data is considered at a UK level as well, through the UK Health Security Agency, and risk assessments of emerging pathogens are produced. An example of that is the consideration of the recent Mpox data from central Africa and how that disease might impact on the UK. We are also keeping a close eye on the way in which H5N1 is crossing from avian sources to mammalian sources and how that affects the risk assessment for the UK.

Beyond what Daniel Kleinberg has outlined, there are technical assessments of risk for individual pathogens, which are fed into the risk assessment process by UKHSA, of which we are a part.

Dr Jim McMenamin (Public Health Scotland): From my perspective in Public Health Scotland, as part of the continual risk assessment process that the CMO has just outlined, horizon scanning is undertaken not only by our organisation but by our UKHSA colleagues and by a number of expert groups, such as the World Health Organization, the Centers for Disease Control and Prevention and various branches of organisations across the globe. That co-ordination network has continued to share information about new and emerging threats to enable the risk assessment process to be undertaken.

I happen to be a member of the UK new and emerging respiratory virus threats advisory group—NERVTAC—which is one of the UK groups that would look at the issue from a respiratory pathogen perspective. I have been a member of that group since its formation. Groups such as that continue to keep a close eye on any emerging threats. They provide advice to the Government of the day and share with the devolved Administrations what those threats might be.

09:30

To come back to the first question and offer some insight, none of us is waiting for the recommendations of the UK public inquiry; rather, we have just got on with things. It may well be that we already discharge many of the recommendations that come through, now or in the future, because the learning of the past has been that we have to take action now. In all that we do, whether that is surveillance or risk assessment and future planning, we respond by having the additional resource that has been provided to all the UK agencies to put us on a firm footing to respond to whatever our bread-and-butter challenges are today, and to ensure that we are in a good position to build on existing infrastructure and prepare for our next challenge. That includes some of the national exercising, which the committee might wish to hear a little more about.

David Torrance: What has been done in pandemic preparedness planning to ensure a greater focus on preventing the spread of a disease rather than on the impact of the disease? A lot of the time we are reactive rather than prepared.

Professor Sir Gregor Smith: How we prevent the spread of an emerging disease will depend very much on what the disease is and the mechanism by which it transmits. Lots of pathogens have pandemic potential, but they exert that potential in different ways. Some spread through airborne and respiratory routes, some spread through contact and some spread through water sources. There are a variety of means by which those pathogens can act, so how we prevent the spread depends very much on the mode of spread.

First, we need to understand the nature of the pathogen and whether it is a virus, a bacterium, a fungus or whatever. It is about learning the characteristics of that pathogen and the means by which it spreads, so that we can take measures to reduce the possibility of its spread. Personal protective equipment remains important in that regard. One thing that has changed since the beginning of the previous pandemic is that Scotland now maintains stockpiles of respiratory protective equipment that can last for up to 12 weeks.

A broader understanding of how the pathogen exerts its effects and spreads from one individual to another will determine the response. As a new disease begins to emerge, it becomes key to get samples of that pathogen in order to fully understand how it transmits and the process by which it exerts its effects on the body. Jim McMenamin might want to say more about that, because he is an expert in that area.

Dr McMenamin: Our capacity to detect pathogens has gone up a gear with the advent of the opportunity to look at genetic fragments of any new pathogen. We came to see that new frontier of whole-genome sequencing as being at the forefront of our Covid response, and it remains at the heart of our capacity to identify infections that might prove challenging.

Beyond that, in the very recent past, a newer branch of that process, called metagenomics, has emerged. Imagine that one of us has travelled somewhere exotic. That person could come back with a range of symptoms that mean that they present to a medical service, but the normal battery of tests for the place where they have come from might produce negative results. Depending on the severity of the illness, that would leave medical professionals scratching their heads.

The advent of metagenomics—that capability exists on our doorstep, at the Medical Research Council and University of Glasgow centre for virus research—has offered us the opportunity to look at new infections that might not have a name yet. Genetic fragments can be identified, allowing the instances of new infections in a population to be identified for the first time. In the events that the CMO has just described—if a new infection results in severe illness that spreads rapidly among the population, with the potential for pandemic spread—metagenomics can offer us an illustrative first insight into what we might be able to do about it.

We have used the metagenomics approach in the very recent past. Children in Scotland were presenting with a liver infection—something called a hepatitis. As at least two committee members will be aware, because of their clinical knowledge, the main way that that infection might present is through jaundice, with children developing yellowing skin and eyes. The presentation was so severe that the children were managed in an intensive care setting in Scottish paediatric hospitals. The normal battery of available tests produced negative results, so the illness was classified as non A to E hepatitis—an illness that was not yet characterised, with the cause unknown. However, the centre for virus research, which is on our doorstep, and an additional unit in England were able to prove conclusively, by looking at the genetic fragments, that the infection presented was a combination of two viruses: an adenovirus and another virus.

That metagenomics potential is the next frontier in the development of our capabilities. That process potentially offers us a unique insight into how, in the future, we might rapidly identify a virus, communicate the threat and deploy treatments or vaccines if they were available.

Professor Sir Gregor Smith: It is worth saying that, in the particular incident that Jim McMenamin has highlighted, the cases of infection in children were not unique to Scotland; there were such cases elsewhere in the UK and, indeed, across Europe. It is a real testament to the Scottish team's expertise, as well as to the infrastructure and techniques that have been developed here, that the team led the identification of the pathogens that were underlying those infections.

Daniel Kleinberg: I will add to that and go back to Ms Harper's question. We are keen to get on with founding the pandemic science partnership that you referred to, because, as I started rather grimly by saying, there is a 5 to 25 per cent chance that we could have another pandemic. Nobody wants to hear that, and nobody wants to hear that it is getting more likely rather than less likely, because of the threat of the potential malicious use of new and developing technologies, and as people travel to different parts of the world as climate instability hits.

What will work in our favour is how much the technology has moved on since Covid, as well as how much investment has been put into metagenomics, whole-genome sequencing and water-based epidemiology, which involves waste water testing. Our ability to look for those things and to characterise and assess them is much better than it was, although I am not an expert like the other two witnesses, especially Jim McMenamin.

Globally, there has been huge investment in the 100 days mission initiative in response to future pandemics. The response focuses on the use of new technologies on vaccines, the mRNA platform and so on, and a huge amount of investment is being put into that. The idea is that, when we find the next one, our chances of responding swiftly and preventing the level of harm that we might otherwise see will be greater. However, it is always a risk management process.

Professor Sir Gregor Smith: It is useful to think about that response as being scalable. That is the really important aspect for me, because we might be facing something that involves the whole country or there could be much more localised outbreaks that involve imported cases of diseases, such as we see now from other countries. If that technology and that approach face the right way, that will allow us to provide a scalable response. It will allow us to identify and manage those cases, whether it be a viral haemorrhagic fever that is already known about or disease X that is yet to be characterised. In the future, the important thing is that, no matter what, we have the infrastructure and the elements in Scotland to be able to respond to that.

Daniel Kleinberg: Sorry—we are getting geeky and excited.

David Torrance: That is all right.

Daniel Kleinberg: The link into the science and research network in Scotland is huge. Jim McMenamin mentioned the centre for virus research, and Scotland has a genuinely excellent research community in that area. Some researchers will tell you that the next step is the use of artificial intelligence to characterise how viruses might behave. You can find something that you have not seen before and, with AI, in a very short period, achieve what might have taken years previously. I think that that is the next technology that will come in our favour. Therefore, whatever is brewing away in a bat cave in some place where we have not been before, we will be able to understand how that is likely to behave and how to respond to that.

David Torrance: Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising national health service general practitioner.

Sir Gregor Smith, you spoke about global surveillance. I want to briefly explore our relationship with the United States of America, given its size, wealth and power. The health secretary, Robert F Kennedy Jnr, has criticised vaccine safety, and he has said that autism comes from vaccines, for example. What is our relationship with the USA like?

Professor Sir Gregor Smith: During the pandemic response, a very strong relationship was developed with the centre for communicable diseases in the United States—the Centers for Disease Control and Prevention. We had regular meetings in which we shared data, and that has continued in the post-pandemic period. Jim McMenamin has taken part in many of those meetings with me.

I think that it is fair to say that there was a period, particularly at the beginning of this year, less data flowed from the CDC than we had previously enjoyed, particularly in relation to the close scrutiny that we undertook with the CDC on the emergence of H5N1 in cattle herds in the US. That has since improved. You will also see that the CDC is back to sharing data extensively on its website.

The CDC is a changing organisation, and we are yet to see how the changes that have been instituted by the new Administration will settle down and influence the way in which the CDC interacts with the world outside the United States. At this stage, my observation is that that interaction is perhaps not as strong as it used to be, and I think that the withdrawal of the US from the WHO creates a significant gap in our surveillance systems globally, not just in the United States. In addition, the loss of funding as a consequence of the United States withdrawing from the WHO means that there is a risk that global surveillance systems will be undermined rather than strengthened.

I have certainly been anxious about that, and I think that the WHO recognises that as a potentially developing issue. Having said that, I am very aware that the WHO continues to take steps to reform itself and, as it carries out that reform, to prioritise actions that allow us to have the degree of confidence that we need about global surveillance systems.

In May, at the 78th World Health Assembly, the pandemic accord was agreed, and international health regulations were strengthened as part of that. I am reassured to a large extent by such global co-operation, particularly the WHO's continued prioritisation of global surveillance systems. That is one of the things that it sees as an absolute must-do.

09:45

Sandesh Gulhane: You both spoke about the excellent work that is being done in Glasgow on viral haemorrhagic diseases and metagenomics. The University of Glasgow, which runs the lab, is very concerned, with funding streams shifting and ending, that it will not be able to provide the 24-hour support that it provides now. When we needed instant genomics testing when a nurse came back from Africa, lab workers woke up and found the code quickly, with the nurse being treated in London. What can we do to make sure that such labs, which are world leading, do not lose funding and close?

Professor Sir Gregor Smith: We are incredibly fortunate to have the work that the centre for virus research at the University of Glasgow gives us. It is a fascinating place. When I had the great privilege of attending a recent conference hosted by the University of Glasgow on UK pandemic sciences, I heard many members of the CVR speak about the innovative and groundbreaking work that they do. My very strong view is that that work must be sustainable. Funding streams from a variety of sources—whether from the research environment or from other sources—must ensure that the CVR is allowed to proceed with the plans that it has in place to continue its viral research.

Dr McMenamin: I completely agree with the CMO on the need for that very important relationship with the CDC to continue. It has been very important for us to be able to share information with each other about emerging issues, whatever the geographical location of the cases.

On the issue that we have just discussed, it is important to say that we do not have just one centre of excellence. Indeed, the whole thrust of having a national Scottish pandemic science partnership is to strengthen the link with all the teams that are involved. Exceptional work is also done at the University of Edinburgh, through our computing resources and by our mathematics associations with the University of Strathclyde and Glasgow Caledonian University in relation to the incident and outbreak issues that we deal with. There is incredible technical expertise across the board in all those settings.

To strengthen our approach, it is important that we are well connected and that we are able to learn from one another—not just in Scotland but internationally. That should be an essential feature beyond our main reasons for existence in Public Health Scotland. We are, of course, involved in addressing inequalities and preparing for pandemics, and we have a statutory responsibility to do that. It is about building relationships with those who will assist us in managing our future problems.

Emma Harper: I do not want to cause shock or alarm to anybody, but how do the scientists who work with humans in tracing the genomics of pathogens and viruses work with our veterinarians, for instance? We have recently had issues with Schmallenberg virus and bluetongue, and there has been foot and mouth in Germany, so I am thinking about the zoonotic aspects of avian influenza, which Sir Gregor has mentioned. How do we work with other scientists to track and trace the potential pathogens from ticks, fleas and other wee beasties?

Professor Sir Gregor Smith: I hope that it will not surprise you to learn that there are very rich contacts and huge co-operation between the medical and veterinary scientific communities in relation to that. In fact, I have regular contact with the chief veterinary officer on developments in her world and disease patterns across Scotland that result from those. What has been very evident to me in the contact that I have had through the scientific networks that have formed around pandemic control—the UK pandemic sciences network, in particular, and the Scottish pandemic sciences network as it begins to form—is that there is one health umbrella under which we are looking at the broad biological threats to both the animal world and the human world.

You are absolutely right. There is a variety of vectors that we need to consider in that space, including vectors such as mosquitoes, midges and ticks, and vectors that have an avian or mammalian source. However, I see very close scientific co-operation on that. In fact, I have recently received presentations on the changing patterns of vector-borne diseases, in particular, across Europe and within the UK. That is a factor that we will need to take much more and closer consideration of as climate change begins to exert its effect across Europe. We have recently seen the emergence of diseases in Europe that have gradually spread their hold from southern areas northwards. We have had dengue fever in Italy and Spain and now even in the suburbs of Paris. It is only a matter of time before we see further spread of such diseases as a result of climate change. We are also seeing changing patterns of illness in the animal world across Europe, which can sometimes lead to the emergence of small pockets of disease in humans. A good example of that is the recent incidence of west Nile fever in Germany and Holland. Those are all issues on which there is close co-operation in the veterinary medicine and human medicine scientific community.

Dr McMenamin: I am delighted that you have raised that, Ms Harper. Last year, we made a consultant appointment in Public Health Scotland. Professor Dominic Mellor came from the veterinary team there and is our lead for veterinary public health. That important close integration in what we are doing is just one example. The CMO took us into one recent example of why that is important. Just two weeks ago, our UKHSA colleagues reported that west Nile virus had been detected for the first time—admittedly in a sample dating back to 2023—in mosquitoes that were local to Nottingham.

The global issues of climate, sustainability and potential public health impact are critical. Indeed, probably the best epidemiologists I have ever worked with are on the veterinary side. I am particularly mindful of the work of Marta Valenciano, who was a colleague I worked with in Epiconcept. There are incredible epidemiologists and we all learn from each other about how to appropriately investigate and manage any new incident, no matter whether it starts in an animal population or in humans.

Patrick Harvie (Glasgow) (Green): Good morning to our witnesses. I will briefly pick up on one of Sandesh Gulhane’s points before I move on to my own questions about the relationship with the US. One of the things that the US Administration is threatening to do is prohibit publicly funded researchers from publishing in respected peer-reviewed journals and potentially to set up alternative journals that look as though they would be guided by the ideology of politicians who have been known to promote conspiracy theories and debunked science. If that happens—if that threat is realised—would you agree that there is a need to re-evaluate US agencies as partners?

Professor Sir Gregor Smith: I would not want to be drawn into speculation about what may or may not happen in the United States until we have firm evidence of the approach that the CDC will take. The CDC is working on various reports that are looking at the patterns of infectious disease and illness across the country, including how vaccine uptake might have impacted on them. I would not want to be drawn into saying what approach is likely to be taken, until I see firm evidence of how the CDC is likely to report on those matters and, in particular, how the reports are likely to be peer reviewed. An important aspect of the science that is produced is not just the provenance of the reports and data and how they are interpreted but how the scientific method is peer reviewed.

Patrick Harvie: If it happens, will that judgment rest with you as the CMO, rather than with ministers?

Professor Sir Gregor Smith: Certainly, the clinical and scientific community would provide advice to ministers about our view on the veracity of any reports.

Patrick Harvie: I will move on. Whatever level of technological and research progress we have—and there have been some positive and optimistic comments about that—the planning and preparedness need to be there if we are to get effective use out of it.

Before Covid hit, the influenza preparedness strategy was, essentially, the only game in town. The devolved Administration in Scotland had adopted it, despite having the option to go in a different direction. The inquiry has found significant flaws with that strategy, not least that it was specific to influenza, which did not turn out to be what hit us. Presumably, that was one of the reasons why the strategy was effectively abandoned early on and the different Administrations in the UK went their own ways with new approaches.

The inquiry noted that there has been some work on various documents since then, but it found that there is still a lack of clarity in how both the problems and the solutions are set out. It recommended a UK-wide whole-system civil emergency strategy. Where are we with implementing that recommendation—both at a UK level and under the devolved Administration in Scotland?

Professor Sir Gregor Smith: I will pass that question to Daniel Kleinberg, who has been quite involved with all of this work.

Daniel Kleinberg: Some of that comes back to my first answer about Baroness Hallett and the response around the wider civil contingencies. However, if we are going into pandemics specifically, one very positive thing that has come out of the past couple of years is exercise Pegasus, which is focused around autumn, with anchor days in September, October and November. It is a tier 1 UK exercise in which all the four nations participate, and it looks at pandemic preparedness. It will test itself against a scenario that will not be known before we go into it or that will be known only to those who design it. For me, that is a good opportunity for Scotland to test how it would structure itself.

The pandemic flu plan from 2011 structured quite a lot of what we did in Covid. It was not fundamental to how we designed our approach, but nor was it abandoned. It creaked and did not work, and people have said why. However, as we learn what we would do next time, two things stand out. One is that nothing in that flu plan envisaged some of the advances in technology, but another thing that it did not envisage was the use of non-pharmaceutical interventions. It did not suggest that, by using social, non-pharmaceutical measures, we could stop flu in its tracks, which we did for two years during Covid. We did not see a flu season for two years. I do not know whether we would reach for that again, but some of the impacts of flu are horrific. A pandemic flu that is felt primarily in young people is a genuinely terrifying prospect, and the fatality rates would be way beyond the rates that we saw with Covid. It is important to think through how we would make those decisions.

10:00

In exercise Pegasus, I would like Scotland to test, as will be tested at the UK level, what we stand up—it might be a respiratory response plan rather than a flu plan, although I still think that flu is a big pick for what comes next, so I do not think that any of us would want to denigrate flu planning. However, we should have a variety of responses.

In exercise Pegasus, we should test the four-harms approach that we used in Scotland during Covid. Ministers took decisions not only on the basis of stopping the virus or disease. Harm 1 was about how we counteracted the virus and the disease that it caused; harm 2 was about pricing in what we might be stopping in health and social care—the impacts of the control measures; harm 3 was about the social impacts, such as the educational impacts; and harm 4 was about the economic impacts. We need to test our ability to make decisions that take into account the full range of impacts, immediately and in the future. That needs to be part of our decision-making framework. It feels to me that we will have those things in place and will test them.

Patrick Harvie: Just as you do not want to downplay the importance of flu planning, I do not want to downplay the importance of pandemic planning in isolation, but how does such planning integrate with a wider approach—what has been described as a whole-system approach—to emergency planning? Planning for a pandemic is very important, but it has to be seen as part of our wider understanding of how the country responds to emergencies.

Professor Sir Gregor Smith: Daniel Kleinberg can respond to that first, but I want to say a little bit about it, too.

Daniel Kleinberg: There is definitely commonality. Whatever else we do, health and social care resilience is likely to be a big feature of just about any of the major contingencies that we plan for. A lot of that happens at the UK level—a lot of it is about financial planning, for example. I agree that the connection into the wider contingencies world is important, but the specificity of pandemics is such that both of those parts of planning have to be run in tandem.

Professor Sir Gregor Smith: I go back to my point that having a scalable response is really important, particularly in relation to how the NHS responds to an emerging threat. There are commonalities, whether the threat relates to winter surgeries and respiratory disease or whether it is the emergence of a novel pandemic. Part of the issue is the scale of the response. We are working through our resilience mechanisms, and a branch of the Scottish Government—health emergency preparedness and resilience and response—is developing new guidance for health in relation to scalable responses.

Patrick Harvie: Will that be specifically for health?

Professor Sir Gregor Smith: Yes. I want to drill down into that issue, because we need to develop that guidance to ensure that the NHS is able to scale our response—whether it be to a malicious threat or attack or to a new or emerging infectious disease—in a way that we would expect.

I want to say a little bit about the second aspect of the contingencies and preparation work, which is about our learning about any emerging disease or pathogen. That is really important, and I cannot emphasise enough the work that has to be done in preparation. UK sciences are particularly strong in being able to analyse and develop scientific learning about the nature of any pathogen threat and, as a consequence, develop interventions that can address that threat. Those interventions might be novel tests, the use of infection vaccines and so on.

Patrick Harvie: I appreciate those answers—it is inevitable that there will be a health focus this morning, given the witnesses—but I am asking about the context. Is that work being done in the context of implementing the recommendation that the UK Government and devolved Governments should work together to introduce a whole-system civil emergency strategy?

Daniel Kleinberg: Something that has been agreed, and which has been signalled to Baroness Hallett in the Scottish Government's response, is that the Cabinet will consider doing biannual papers on whole-system civil emergency.

Patrick Harvie: Is it beginning?

Daniel Kleinberg: That work is certainly beginning. I am not as familiar with that as with the pandemic side of it, but it is under way, I would say.

Dr McMenamin: I have one additional point to make. The national Scottish pandemic sciences partnership is not only looking at what we would do for the hard sciences, such as laboratories and data, but, just as importantly, considering the behavioural perspective. What do we need to do to keep the trust of our population? What do we need to do to ensure that we can discuss some hard things that will, potentially, have to be discussed at the time? Stephen Reicher and other colleagues will be able to make an incredible contribution to work on how we will address those issues.

Patrick Harvie: That brings us on to my final question. One of the flaws that were identified with the 2011 influenza preparedness strategy was the lack of an economic and social dimension to it. That covers a great deal that is non-medical and not specific to a health pandemic but still very relevant to a health pandemic, and it would have been relevant five years ago.

Trust and trusted sources of information in an age of disinformation are very important, as is community infrastructure, so that people know where they can get help informally and quickly. Are we investing in those community organisations and relationships? We have not been for 15 years or so.

There are also very basic things such as homelessness. Having safe, secure and adequate housing is important to keep people safe in any emergency, particularly during a pandemic. Can you comment on the extent to which a connection—beyond the direct medical and public health response to a pandemic—is being made to the social and economic conditions that will enable us to weather a storm?

Professor Sir Gregor Smith: Daniel Kleinberg might want to say a little bit about that first, and then I will come in and speak about working with the population in relation to that.

Daniel Kleinberg: Pandemics exacerbate underlying social and economic inequalities; that is just a given. I do not think that it is for me to comment on the wider socioeconomic policy. We have a better understanding of how we would support and reach out to vulnerable groups because of the Covid pandemic. Continuing with that work is important, as is some of the learning that we took from trusted sources of information. I agree with what you said—that is an important part of where we need to be.

Professor Sir Gregor Smith: Data is key in all of this. Data was one of our blind spots, particularly at the beginning of the pandemic. It got better as the pandemic response went on, but we need to ensure that we have the right data to inform us of where the pandemic is particularly likely to have a more severe impact. As Daniel Kleinberg said, in every pandemic over the ages, back to medieval times, the most disadvantaged have tended to suffer the worst effects.

What is interesting, having taken a retrospective look at the impact that the Covid-19 pandemic had on people, is that evidence from across Europe identifies that countries that already had challenging trajectories for improving healthy life expectancy, particularly relating to cardiovascular disease, tended to fare worse than the countries that had been able to maintain their trajectories of health improvement in such areas. Therefore, creating better health resilience in the population has to be a target, so how we work with communities to ensure that we are creating healthier communities is essential.

The work that proceeds on reducing inequalities not only has an effect on improving the health of the population now but makes us much better prepared for the impact of the next pandemic, in the event that there is one.

Patrick Harvie: From the public health perspective, public health is fundamentally shaped by social context.

Dr McMenamin: The marginalised or seldom-heard-from individuals in the population are at the heart of what we are trying to do through our routine public health offer. However, as the chief medical officer has just taken us through, that is just exacerbated whenever we are faced with a pandemic issue.

Data is at the heart of everything that we need. I am delighted that we have made such significant progress on our capability to link data, because the Scottish population would expect us to be able to say whether the interventions that we make work. What is the reduction in hospitalisation? What number of lives are saved by whatever we are trying to do? That comes back to the point that I have just made, that it is fundamental to maintaining the trust of the population to bring them with us on any journey that we make in the response.

Patrick Harvie: Thank you.

Paul Sweeney (Glasgow) (Lab): I thank the witnesses for coming. Sir Gregor has hinted at the theme of some of my questions. The module 1 report highlighted the importance of data and research when we are responding to a pandemic. Professor Patrick Vallance told the UK inquiry that there was a paucity of data, and I think that Sir Gregor just echoed that point. In Professor Patrick Vallance's words, the UK Government and devolved Administrations

“were flying more blind than you would wish to”.

Issues were identified around the lack of formal structures for the Office for National Statistics to contribute to preparedness planning, as well as a lack of compatibility in data systems across the four UK countries. At paragraph 4.75, the report identifies that

> “This means that, despite England, Wales, Scotland and Northern Ireland being at risk of the same health emergency, the data and health systems were so different that they were a barrier to effective preparedness.”

Could members of the panel comment on that paucity of data, which the UK Covid inquiry identified as a weakness? What work is specifically under way to establish countermeasures to those weaknesses so that we have appropriate and reliable data systems across the UK?

Professor Sir Gregor Smith: I will begin and then turn to Jim McMenamin, who will be able to expand a little on some of the specific data sets that we have developed since the pandemic. Actually, we used those extensively towards the middle and later stages of the pandemic, but you are right that, in the early stages, actionable data was difficult to come by in developing a response. That was partly because, in the early stages of the response to any emerging pathogen, there is a learning process in trying to determine key aspects such as transmission rates or case fatality rates.

Although the UK had good mechanisms by which that information could be derived, none of those was particularly rapid and they depended on the number of cases that were being seen to develop the information. That has all been looked at and thoroughly examined as part of the response to what is likely to happen the next time.

Over the course of the pandemic, developing data became a feature of paramount importance, as did sharing data across countries. You are right that there were points during the pandemic response when data was not directly comparable across the four nations, because definitions were used in a slightly different way or the data was collected in a slightly different way. The more that we have a confluence of approach in that space, the better.

The data world in Scotland has progressed significantly since those early days. As I said, even during the response to the pandemic, we saw much more sophisticated data systems. Jim will no doubt speak a little about the EAVE II platform, which he was extensively involved in and which became a fascinating and trusted source of information on how, for instance, vaccines were exerting their effect on the population.

I am much more confident now, but there is more to be done. One important aspect of the work of the pandemic sciences network will be ensuring that we have data platforms and have identified the means to collate and link data. That latter aspect is particularly important to ensure that, the next time, the response is as effective as it can be across all groups of society.

10:15

Daniel Kleinberg: Before we hear from Jim McMenamin, I would like to add something that relates to Mr Harvie's point. One of the sub-groups of the standing committee on pandemic preparedness is looking at data, and we have learned from colleagues on that group that they have been working very closely with the UK Government's Cabinet Office on the use and sharing of data for emergency preparedness generally—not only for pandemics, because a lot of the material is common. A memorandum of understanding on that, which will be part of an analytical framework, will be signed by the Cabinet Office and devolved Administrations in the coming weeks. That embodies the idea of collecting and sharing data across different types of crisis.

That also raises the need for us to have a conversation about the issue with the public, because what we would want to know in a pandemic might include data on people's movements and so on. How such data could be collected fairly, decently and transparently is hugely important.

Dr McMenamin: I will come back to the area that the CMO took us into. The work of the University of Edinburgh's Usher institute was extremely important in enabling us to deliver for the early estimation of vaccine and anti-viral effectiveness—EAVE II—study. That had its origins more than a decade ago, in 2010-11, when we thought that it would be a good idea to have the capability to link general practice information with hospitalisation data, data on vaccination status, laboratory data and death data.

That approach was in place in a hibernated project that had been jointly developed with a predecessor organisation to Public Health Scotland—Health Protection Scotland—in which I was based. I was one of the folk who took that through the ethics committee for approval at the time.

That approach stood us in such good stead for the deployment of the Covid vaccines that Scotland was the first country to be able to produce a national estimate of the effectiveness of vaccination in the first wave. My colleagues in Public Health Scotland agree that that was not only of critical importance in enabling us to demonstrate the effectiveness of a vaccine in allowing us to find a path out of some of the societal restrictions that were in place but was of great utility for the rest of the UK and the international community. That work was intensely covered by a number of international reports in Washington, New York and elsewhere. All that information allowed the world to change its perspective and continued to enforce the message about the usefulness of the vaccines that we had available to us.

Paul Sweeney: You have given us a helpful and encouraging insight into Scotland's underlying data picture. Inevitably, however, I want to focus on areas of development. What work is being done specifically to improve the data systems? What projects are being commissioned? How will new systems be tested? Are there exercises in the pipeline? Is there a timescale for when data systems are likely to be tested in a pandemic simulation exercise? Will that happen in the next few years? What new hibernated studies or existing studies are being developed? It would be good to get a more specific indication of what work is under way in the light of the learning from the Covid-19 pandemic.

Professor Sir Gregor Smith: Jim McMenamin can say a bit more about data, while Daniel Kleinberg will be able to talk about exercises.

Dr McMenamin: I offered the example of what we did with the EAVE II study. Using a similar approach, we were able to do a whole-UK study for the first time, called COALESCE—the "Capacity and capability Of UK-wide Analysts to LEverage health data at Scale using COVID-19 as an Exemplar" study. In that study, we addressed what the CMO just discussed: ensuring that we have data comparability among the constituent bits of the UK and are able to offer insight into how we would undertake such work in the future. That is really important and sets the scene for where we are and what our capabilities are, much of which we have also covered in setting out the ambition for what the national Scottish pandemic sciences partnership will offer. We are trying to ensure that data provision and data flow, as well as the information governance around that, are all in place in advance and that any amendments can be rapidly implemented to allow early sharing of information for action.

Daniel Kleinberg: There is a data strategy within the Scottish Government for health and social care, which includes a creating data for insights programme. We already have Scottish dashboarding for key indicators across health and social care, so developing that further is already well in hand.

When it comes to exercises, I spoke earlier about the four-harms approach, and that is what I would expect us to use in exercise Pegasus. In order for ministers to make decisions, they need data and analysis on each of the four harms that I mentioned—the best economic, social and educational data that we have at the time. I expect us to be standing that up, seeing what data sources are online and working well, and where those gaps are felt to be when we test it out. Pegasus is a really good chance to have a look at that.

The Convener: Thank you. We are over an hour into our session and we have reached only the halfway point of our questions, so I ask members to be concise with their questions and witnesses to try and be more precise with their answers. I will go to Stephanie Callaghan.

Ms Callaghan is not online—oh, she is there.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Sorry, convener. I could not unmute myself.

Given the 5 to 25 per cent chance of a new pandemic that has been mentioned, learning from past experiences will clearly be crucial. I will focus on the planned autumn exercise, which is not that far away. The UK inquiry identified a number of limitations across previous exercises. Can the witnesses detail how this year's Pegasus exercise will be different from previous exercises, particularly around containment strategies, following up recommendations and addressing the disproportionate impact that falls on vulnerable people and groups that we have already spoken about?

Daniel Kleinberg: I do not know whether it will be different, but Pegasus will publish the learnings from the exercise. The UK has indicated that it wishes to publish a pandemic strategy, for example, which will be informed by the findings from Pegasus. However, for me, what is key with all such things is, once we have identified the lessons, to say how we will implement them, who will implement them, and where they will be implemented. I cannot really speak further about the details of Pegasus, because the nature of an exercise is that the detail is revealed only at the point at which you go through it.

Stephanie Callaghan: I am wondering how confident you are that those actions and follow-ups will happen, because that has certainly been quite a weakness in the past.

Daniel Kleinberg: I am confident that there is a very high level of interest, scrutiny and willingness to learn those lessons. I am confident that many of the lessons that were identified in the past are in hand, but what we have not done is report back on them in a way that fully makes that transparent. All of that is likely to be better under exercise Pegasus, because I suspect that the level of scrutiny and interest post-Covid will be greater and the need to learn those lessons is shared. The best that I can say at the moment is that I am hopeful.

Stephanie Callaghan: The inquiry report also recommended that guidance should be kept in a single UK-wide online archive, which would make it much easier from the sharing and access point of view. What work is under way to develop the UK online archive, and is there an expected timeline for completion?

Professor Sir Gregor Smith: I am sorry, convener, but I did not catch the question.

The Convener: Ms Callaghan was asking about the development of a UK online archive to allow data to be shared more effectively.

Daniel Kleinberg: Is that about data guidance?

Professor Sir Gregor Smith: I am certainly not aware of a UK data archive or of moves towards the development of such an archive, and I have not been involved in any discussions about that.

Daniel Kleinberg: I think that you were asking about guidance—it is a slightly bad line. One of the things that we are doing under the future pandemic work is looking at guidance. Public Health Scotland stood up an awful lot of guidance under Covid. A lot of that is likely to be the sort of thing that would be needed again in future pandemics, but we are refreshing it, understanding it and placing it into the Scottish context. One of the challenges with guidance is that many of the principles in relation to the disease are the same, but the deployment and the response are often local. We have a cell looking at guidance in Scotland.

Stephanie Callaghan: That is fine. Thank you, convener. I am aware that the line is quite bad.

Sandesh Gulhane: I will focus on key lessons for future pandemics. Daniel Kleinberg spoke about the likelihood of another pandemic in the next five years being up to 25 per cent. Covid variant NB.1.8.1 is the dominant strain in China. There has been a huge surge in hospitalisations, and it is more contagious than previous variants. It has spread to 22 countries and accounts for 10 per cent of Covid cases worldwide. Is that of concern here? If so, how prepared are we for that variant?

Professor Sir Gregor Smith: We have been watching variant NB.1.8.1 for some time and looking to see how cases of it develop. You are right that some of the statistics that have been reported from China, in particular, suggest that there has been a rise in hospitalisations associated with respiratory problems, and the number of emergency department presentations seems to have risen in China, too. We are also seeing the variant in pockets of other parts of the world. In the United States, some states have issued advice on it. The variant is not ubiquitous; at this point, it seems to be fairly localised with regard to where it is exerting its effect. However, from a relatively low baseline globally, we are now seeing a rise in the number of Covid cases that have resulted in hospitalisation.

There have been some cases of the variant in the UK. Jim McMenamin and I had a conversation earlier about that and about the analysis that is being done to try to make an accurate assessment of any potential impacts, particularly in well-vaccinated and exposed populations. Jim might want to say more about the work that Public Health Scotland is doing on that.

Dr McMenamin: As the CMO has just described, it is early days with regard to what we might see as a consequence of that genomic type of Covid. In our current surveillance arrangement, we have an opportunity to use whole-genome sequencing, which is undertaken on Scottish samples, alongside colleagues in the rest of the UK, to look at whether there will be any more than just the penny numbers of cases that we currently have or whether the variant will become more dominant among the different variants that are reported across the UK population and particularly in Scotland.

For individuals who have the infection, we would consider the profile, including what age groups are affected and whether the infection shows an ability to hurt people more than any of the other Covid variants. We continue to look at hospitalisations and intensive care unit activity to see whether it will be an issue for us. At the moment, it is too early for us to say from the early information that we have on the infection whether it will translate into more of an issue for the Scottish and UK populations.

10:30

Professor Sir Gregor Smith: For me, more than anything, that emphasises the on-going need for vigilance and surveillance not just of the way that the Covid virus inevitably will develop over time—we have seen it develop different characteristics during the five years that we have been aware of it—but across the broad respiratory pathogen network, to ensure that we have robust mechanisms in Scotland to pick up different patterns of disease presentation. Public Health Scotland has very good respiratory surveillance data, which is used extensively to look at the emerging picture of infections across all the respiratory pathogens in Scotland. Dr Gulhane previously mentioned global surveillance data, and that is why global co-operation on data sharing is so important.

Sandesh Gulhane: Let us assume that that variant or something else comes along next week or in the next couple of weeks. What is our preparedness level like right now? You spoke about having 12-week stocks of PPE, but what is in those stocks? As far as I am aware, the common mask that we tend to use becomes useless after about half an hour. Do we have enough stock of real PPE that could go out to GPs, social care workers and others who are on the front line?

Professor Sir Gregor Smith: The short answer to that is yes. Just now, in Scotland, we have 12 weeks of PPE stock of an amount that is comparable to peak usage during the Covid pandemic, and distribution mechanisms have been developed for that. We have scalable assets across Scotland, whether that is medical equipment or ICU departments. If necessary, we are able to double our ICU capacity, and we have platforms that have been mothballed but kept under licence that can be brought back into play to allow us to develop the data and the infrastructure for contact tracing at scale. There is scalable infrastructure in Scotland that can be rolled out should something necessitate a wide response.

Sandesh Gulhane: You spoke about data being king. Would it be helpful if we had a single information technology platform across health and social care in Scotland that we could harvest data from?

Professor Sir Gregor Smith: I can give you my view on that. There are many reasons why there would be tremendous advantages from a single digital platform that links data, with appropriate access, across health and social care.

Sandesh Gulhane: Daniel Kleinberg spoke about the harms that were caused—not just health harms, but many other things. Lockdown caused harms to our mental health, hospitals could not facilitate cancer treatment and children who were going through school suffered harms. In my opinion, the evidence on lockdown is not great; it is really about vaccines, not lockdown. Where are we with potentially having to use a lockdown again in a future pandemic scenario?

Daniel Kleinberg: One thing that we did not mention about that Covid variant is that although, at the moment, we have no idea what it will do, if it were causing a threat we would consider vaccination.

On the future use of social restrictions, I do not have an answer as to when to use them, because that is a political question. The best that you can say is that, once you have understood the threat that your society faces, and once you have characterised the severity and profile of the disease, you can begin to offer an analysis across the different considerations.

The withering effects of a high level of social restrictions are uncontested, but you do not have a good option, because you are measuring those against the potential impacts on people—if the disease profile is different, it might be young people—and your ability to keep your society functioning. Those are, by definition, questions for the disease and the politics of the day. I have nothing better to say about that.

The more that we can understand the longer-term impacts of those social restrictions, the better. For example, we did not know that they could stop a flu, but they did, which is something that we should learn from. Equally, we are still learning about the longer-term educational and socioeconomic impacts.

I do not have an answer as to whether we should use them. That is a question for the politicians of the day.

Sandesh Gulhane: Thank you.

Carol Mochan (South Scotland) (Lab): The UK inquiry's module 1 report emphasises the importance of surge capacity in the NHS and says that that was not planned for in the simulated exercises. Given that the NHS and social care sectors were found to be unable to "surge up" at the onset of the pandemic, to what extent do you think they could deal with that now, given that we are still catching up after the pandemic? Where are we on that, if we needed it in the future?

Professor Sir Gregor Smith: The efforts made by the NHS and social care across Scotland throughout the pandemic were nothing short of phenomenal. The really significant sacrifice that staff across all professions made to make sure that people received the care that they required was exceptional, but we cannot rely on that as a response to the next time. We need to make sure that there is adequate planning in place for surge, no matter what the cause of that surge.

This is the point that I wanted to bring out earlier. We might need to surge the NHS, in particular, for all sorts of reasons. It could be because of the emergence of a particularly bad flu or winter season, a response to a malicious attack or the global instability that we see abroad. On the NHS's ability to surge, the Government is currently undertaking a piece of work in the health resilience area to see how it can work with our various health boards on surge planning and capacity. We already have the means to surge in particular specialties such as critical care if that becomes necessary.

There is no doubt that the NHS has never been as exceptionally busy as it is now, and to work in the NHS is a difficult job for my colleagues because of the volume of very complex illness that they continue to see. Some of that is a consequence of our experience during the past five years, particularly the pandemic, and some is related to changing patterns of disease in an ageing population.

Surge planning is a key aspect of the work that is under way on how the NHS will respond in future. We have partnerships between local government and the NHS. The resilience partnerships across Scotland also play a key part in ensuring that all assets in the community, across social care, third sector organisations and statutory organisations, can play their part in that.

Carol Mochan: I am pleased to hear you talk about resilience across the NHS and social care. The pandemic shone a light on the need to ensure that the parties in that relationship are equal and are considered at all times. Is enough work going on among the Scottish Government, NHS boards and local government for that to happen, were we to see a pandemic in the near future?

Professor Sir Gregor Smith: That work is under way, and, when we proceed further with it and can report findings and approaches, I will be able to give you a more complete answer to your question.

Carol Mochan: That is helpful; thank you.

Joe FitzPatrick (Dundee City West) (SNP): It is good to see you all. I want to go a little further on the WHO, which you touched on in answering Sandesh Gulhane's questions. The suggestion of a pandemic international agreement was first mooted back in 2021 and was agreed by the World Health Assembly on 20 May this year. It would be good to hear a bit more about what that means for Scotland. If you want to make a pitch for why other countries should join it, it would be helpful to hear about the benefits.

Professor Sir Gregor Smith: I would state unequivocally that that is a good thing for Scotland. Although we do not have a direct relationship with the WHO, our relationship is strong through UK mechanisms. It will not surprise you to hear that the UK CMOs still spend a significant amount of time in discussion, particularly in order to share information and approaches as they relate to the WHO.

I welcome the pandemic accord and the update of the International Health Regulations 2005 that sit alongside it. There is still work to be done, particularly around pathogen sharing and so forth, and that work will proceed in the months ahead. The accord puts us in a significantly better position globally. I see the WHO as being the organisation that can co-ordinate the response globally and ensure that the surveillance mechanisms on a global scale are present and working to give us an early warning of any emerging or potential threats.

An important aspect of the accord is having the legal basis on which people will co-operate and share information. Although it has been a long time in the making—it has taken more than three years to negotiate with members—the weight of support that you saw at the 78th World Health Assembly is significant.

I absolutely wish that all countries in the world had signed up to the accord and had continued to support the WHO. Having a country that is as significant as the United States, which has much to offer with its scientific basis, step away from the WHO means a weakening of the global position. That does not enhance the capability of the WHO, and I hope that the position is reversed at some point—certainly in my lifetime.

Dr McMenamin: I cannot add much to what the CMO has offered other than to say that that is a very laudable approach that all countries should consider. I am delighted that the accord is in place.

I will mention one component of the accord that is important for us. Vaccine availability is, of course, critical whenever we have any new emerging threat, and ensuring that the most disadvantaged countries have access to a proportion of global production is essential. Every developed country should look on that as an important aspect of what needs to be covered.

Joe FitzPatrick: That is a really interesting point, which you have added just at the end of our time for questions. I see the convener pushing in, but I will ask one more question and maybe let Daniel Kleinberg have the last words. How can we get across the message that it is important for us all that the whole world works together? Health in Africa, for instance, is just as important to us here, in Scotland, as it is to people in Africa.

Daniel Kleinberg: I can see from the convener's eyes that my answer should be short, so I will go back to something that one of our scientific advisers said during Covid. It is a commonplace saying. No one is safe until everyone is safe. Therefore, anything that boosts the international rules-based order is a good thing for public health. How it is done is a second-order issue for me, but that is what we have been saying.

The Convener: Thank you for your brevity, Mr Kleinberg, although I am a bit concerned that you can see into my eyes from that distance.

I thank the witnesses for their evidence this morning. It has certainly given the committee a lot of food for thought. You have given a lot of information about the work that is being done, perhaps not as publicly as it might have been before we were able to ask you about it.

I suspend the meeting briefly so that we can change witnesses.

10:46

Meeting suspended.

10:55

On resuming—

Mental Welfare Commission for Scotland

The Convener: Welcome back. The next item on our agenda is our periodic scrutiny of the work of the Mental Welfare Commission for Scotland. I welcome to the committee, from the Mental Welfare Commission for Scotland, Claire Lamza, executive director of nursing; Suzanne McGuinness, executive director of social work; and Julie Paterson, chief executive officer. We will move straight to questions.

Sandesh Gulhane: I declare an interest in that I am a practising NHS GP.

Thank you for coming along today. I want to start by discussing the BBC's "Disclosure" documentary, which raised serious concerns. Could you explain why issues were not identified and acted on sooner? What action is now needed to ensure that the failings are not repeated?

Julie Paterson (Mental Welfare Commission for Scotland): The documentary was hugely concerning. It was awful to hear about the experience of the five young people over that seven-year period. You will be aware that, on two occasions in that seven-year period, the Mental Welfare Commission visited the setting on an unannounced basis.

We are reflecting on those concerns in our work. As you know, we are not an inspectorate or a regulator. We do not have the powers to close wards that a regulator would have. The Care Inspectorate can close care homes; we do not have those powers.

Sandesh Gulhane: If you had had those powers, would that have made a difference?

Julie Paterson: As was stated in the Scottish mental health law review, we require additional powers. However, our reflection is that we could do things differently. As you know, when we visit services, we visit them for a day, so it is a snapshot in time. Our focus is based on the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000—our duties and powers relate to those laws.

When we meet people on the wards, we want to hear about their experience and what matters to them. We also want to hear from families and carers, as well as the staff on the wards. Not everybody on the wards feels able to speak to us when we visit. We need to reflect on and understand why that is, because it is really important that we hear a range of views and experiences. We have been reflecting on how we can engage with people—young people in particular—more. That could include not just being on a ward on a one-day basis, but having a greater presence on the ward. If we were there over two or three days, for example, people might get to know us and feel more able to speak to us.

We are also reflecting on how we can engage with people who attend the ward. For example, mental health officers who are social workers who work with young people and adults who are detained under the mental health legislation routinely visit people on the ward. What can we do to engage with them more to hear about their experience and what they have witnessed? If they have concerns, how do they address them? How do they raise them? Everybody has responsibilities in relation to child and adult protection. We are reflecting on how we can enhance our visits, rather than providing a snapshot on one day.

Sandesh Gulhane: You say that you are reflecting. What is your reflection?

Julie Paterson: That is our reflection. We will start to undertake enhanced visits to learn about the approach that we are planning to take to improve the work that we do.

It is important to say that our functions are very much set down in law; we cannot force people to speak to us. In the documentary, one person said that they thought that their experience was normal in that setting—they did not appreciate that it should not have happened. We need to do more work to ensure that children and young people, and adults, are aware of their rights in a care setting so that they know what is normal and what is not.

11:00

We have work to do collectively with the other professionals who attend and visit the ward, with the staff who work on the ward and with the families, carers and young people. We need to engage across the board—we have a shared responsibility to ensure that we engage with all those people.

Sandesh Gulhane: You are going to visit those settings, but how do we ensure that we never get into a position in which that type of abuse is happening? As a medic, I was horrified to see from the documentary that people had been treated in that way by fellow professionals. What is needed to prevent such a situation from even beginning?

Julie Paterson: The Mental Welfare Commission's roles and responsibilities extend beyond visiting. We visit, as I have just explained, but we also provide advice and guidance on best practice according to the law and on what people can expect in relation to their rights being respected.

We also undertake investigations and, when we are made aware of concerns, we will investigate them at various levels. They can be addressed locally or they can lead to a 12-month investigation by the commission, which will lead to a publication.

We also have an advice and guidance line for people to call us on, and we receive about 3,500 to 4,000 calls each year. Those calls can involve providing advice and guidance on what people can expect from their care and treatment, or they can involve people raising concerns about the care and treatment that they are receiving. In addition, families or professionals might raise concerns or ask questions. About 49 per cent of those calls come from people who are using services or from carers or relatives, and 51 per cent come from staff who are working in mental health settings.

From that work, we are able to highlight the concerns that exist, and that will inform our work, too. For example, the committee may be aware that we published "Authority to discharge: Report into decision making for people in hospital who lack capacity" in May 2021. That work came about because individuals had raised concerns through our advice line that people were being moved from hospital to care homes unlawfully. People who did not have the capacity to make decisions about moving to a care home during the Covid pandemic were moved unlawfully, and we would not have known that had people not contacted us on our telephone advice line. That led us to do the work that we did, which led to the training programme for all staff in relation to adults with incapacity.

We do a range of work that comes together to enable us to try to mitigate any experiences such as the experience that you described at Skye house. We can only do our best, in partnership with everybody else, to make sure that that experience cannot be repeated and that we learn from it.

Sandesh Gulhane: Did you receive any calls about Skye house via the phone line that you just mentioned?

Julie Paterson: I am aware that we received one or two calls in relation to individuals, and we picked up those issues and addressed them with the service over the seven years. We work very much with individuals, but, when we find that there is a range of issues, we will go in and do more detailed work. We did not do that in relation to Skye house, but there will be other areas of work in which a wealth of information has come through that will lead us to act and undertake more enhanced or detailed visits.

Sandesh Gulhane: How transparent is the process of looking at cases and deciding what merits an investigation taking place? If you had received calls about Skye house during those years, that would raise a lot of concern, given what happened.

Julie Paterson: We receive calls from individual people, and we address those on an individual basis. Our focus is very much on individuals, not on services. I direct you to our investigations in relation to Mr E, AB and Mrs F. We focus on the individual circumstances of each person.

When there is a range of people and the issue is more systemic, we will probably refer that to a regulator, for example, but in the circumstances that we are talking about, it is about individuals. Our practitioners pick up individual cases and address them, and when the issues are not addressed, they would raise those. We work with individuals at every level, and we work with a number of individuals across a range of services throughout Scotland in the hope of addressing the circumstances for those individuals. That is our focus.

The Convener: I declare an interest in that I am a registered mental health nurse with current Nursing and Midwifery Council registration, and I am employed as a bank nurse by NHS Greater Glasgow and Clyde.

You talked about hearing and listening to views, and you said that you see a snapshot and are considering enhanced visits. However, over that seven-year period, there was obviously very poor practice—if I can put it as mildly as that—in Skye house that the Mental Welfare Commission appeared to be completely oblivious to. What will you do to ensure that you do not miss that in other areas?

Julie Paterson: I will pass over to Claire Lamza to say a wee bit more about Skye house and the work that we did, and then I will answer the question about what we are going to do in the future.

Claire Lamza (Mental Welfare Commission for Scotland): In response to the point about us being oblivious, I go back to the fact that it is a one-day snapshot that we take. For those who are not aware, I point out that it is a one-day visit. There might be two or three practitioners out of the group of 19 staff from the Mental Welfare Commission. They are knowledgeable, experienced and experts in their field, so they would not be oblivious. However, if the visit has been announced, the focus on the day will be the people who have indicated that they want to speak to us. If the visit is unannounced, we go round and find people who are willing to engage—that might be family members who are visiting.

A lot of the effort and energy on the day of a visit goes into co-ordinating and getting views on that day. We might speak to staff, individuals who are happy to speak to us and family members or carers who are there. After that, to get corroborative information, we would have an opportunity to review the records.

I have found that, during that seven-year period, we acknowledged that things were going on at Skye house, and there were changes. Before the pandemic, there were issues with staffing. Across Scotland, the commission has repeatedly raised our concerns about the use of agency and bank staff, which came through strongly in our reports—

The Convener: On that point, from looking at our papers, it seems that the terms “agency staff” and “bank staff” are interchangeable for the Mental Welfare Commission, but they are completely different things. Are we talking about agency staff, bank staff or a combination of both?

Claire Lamza: It is both, because both were used in the Skye house team.

At that point, we highlighted that, at times, there were not enough staff. At times, there were agency staff who did not know the environment. At times, there were bank staff who clearly knew the service and would come in if numbers were down. There were concerns about staffing.

The other thing that came through in the records and our reports was about the complexity of and the change in the group of people who were coming in. We highlighted that in our most recent report, in which we said that Skye house was working on the model of care because it recognised that there were more young people with eating disorders or with autism spectrum disorder. All the way through, we have highlighted concerns, whether those have been about staffing, the type of staff or the model of care.

Across all our mainstream work, the commission uses recommendations. The recommendations support us in influencing and challenging practice, within our legal parameters. That has been our route, rather than using requirements or standards that we work to. We have been aware of concerns and have raised them in the way that the commission does, through our processes, whether those are about what we have heard, the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000, or activities.

We have taken the intelligence that we have gathered on one visit and used it repeatedly—for example, the report for 2023 highlighted findings that we picked up in previous years. I think that we wrote that we had raised the issue in previous years, rather than it being a one-off.

The Convener: I absolutely get that, but the Mental Welfare Commission did not seem to pick up on the malpractice that was occurring in the unit, despite the numerous visits and despite other issues being raised that might have rung alarm bells. You say that you make recommendations. Do you think that the Mental Welfare Commission needs more teeth?

Claire Lamza: We have made recommendations repeatedly—that is what we have talked about reflecting on through our intelligence focus. That ties in with other work that has come through from the sharing intelligence network, the Scottish mental health law review and the review of forensic mental health services about the role of the commission, what would be useful for assurance and scrutiny, and how the process could be more robust.

There are bits of work in which recommendations have been made on how the commission should move forward. We have to repeat recommendations, because that is how we have used the processes and systems until now. Having more teeth, to the point that we would have the ability to use them, would be useful.

Emma Harper: Good morning, and thank you for being here. I declare an interest in that I am still a registered nurse. My background and experience are as a general nurse.

I am interested in the Scottish mental health law review, which made some recommendations. The convener has already touched on this a wee bit. Given that the Mental Welfare Commission does not have enforcement powers, how does it ensure that the recommendations that it makes following its visits lead to meaningful service improvements?

Julie Paterson: To answer Ms Haughey’s question about whether we need more teeth, the answer is yes, we do. In response to your point, Ms Harper, we are not a regulator, so we do not have powers to compel anything to happen. As Claire Lamza explained, we rely heavily on our influence and expertise, which works to a certain extent, but there are areas in which we need additional teeth in order to deliver changes.

That point came through in the Scottish mental health law review, which recommended that we should have more teeth. The review, which involved three years of evidence gathering, was very clear about the need to extend the Mental Welfare Commission’s powers and strengthen our role. We very much welcome that, and we are keen to see where those recommendations land and how they progress.

The review talks clearly about the practice that Ms Haughey referred to, and the chapter on coercion recommends a range of additional powers for the commission. That links to some of the practice that we heard about at Skye house, such as the use of restraint. We would like to monitor restraint across Scotland more, because that is a key area in which practice is not currently monitored in the way that we would hope.

The Scottish mental health law review made 202 recommendations, a number of which relate to the Mental Welfare Commission. We are keen to see those progress, because we need additional powers. At the minute, we use our influence, which works well. Claire Lamza will give more detail on this, but we make recommendations through an investigation report or a visit report. Since 2021, we have been publishing the responses to our recommendations, so that we can show evidence to the public that we are closing the loop on recommendations.

We make recommendations, but the feedback from some people is, “So what?” We have started publishing our reports in order to say, “Here’s the ‘So what?’—here’s what the service has done in response to what we said we would do.” We follow up three months after every visit, and we follow up after our investigation reports. We did not previously publish reports about what had been undertaken in response to our investigations, but we have started doing that as well. It is important that, when we make recommendations, people have confidence that action is being taken and that we can publicly share that.

Emma Harper: A seven-year period is covered in the Skye house documentary. You have talked about unannounced visits and other visits. How many visits are we talking about, especially if you go back to investigate three months later? Do the visits involve speaking to the staff and the teams on the ground in each of the three ward areas? I am curious as to why the culture—which, as the documentary showed, evolved into something quite disturbing—was not picked up on sooner.

Julie Paterson: Absolutely. To clarify, we do not go back after three months—we provide a report with recommendations, and we expect a response and an action plan after three months.

I will pass over to Claire Lamza, who will explain exactly what we do on the ground for visits.

Claire Lamza: We start off before the day of the visit. In general, most of the areas that we visit are known by the area co-ordinator—that is the case for Skye house, in particular—so information is already available, and we would look for intelligence.

Before we visit, we will already have spoken to the team, the senior charge nurse and the nurse managers, and we might have spoken to other members of the multiprofessional team, to get as much information as we can. On the day of the visit, there might be two, three or four members of staff. Skye house is a big service, so, on any particular visit, there might have been three or four individuals looking at a particular area. However, as we have said, if the visit is unannounced, we might not find the same number of people who are willing to speak to us.

11:15

With regard to children’s and young people’s services, getting engagement during a one-day snapshot visit can be almost as challenging as it can on a visit to an adult acute ward where people are very unwell. There might be people on the ward who have no contact with the commission because they are there of their own volition. A range of factors might affect how we get intelligence on that particular day.

As Julie Paterson said, we might discover things from the information that is gathered during the visit. With regard to the individuals who we saw that day, it might be that there was no use of restraint or intramuscular medication for us to follow up on, but, if there was, we would check through the process. Fundamentally, however, we build our report around what we find when we speak to people. When we did our reports in 2022 and 2023, there were people who said that their experience was positive. Therefore, what we find is contingent on a number of factors with regard to what happens on the day of the visit.

As you will see from some of our visit reports, when we are concerned and we get intelligence during the pre-visit work or on the day of the visit, or post-visit follow-up information that we ask for or get from our feedback session, we have an opportunity to confirm that information or to get more details through that approach. We will then go back within the six-month timeframe, because there is a three-month period from the local visit to the report being published and our processes taking place, and there is then a three-month opportunity for the service to respond to our recommendations. Primarily, it will do that in an action plan. If we have concerns, we go back.

On Skye house, it was devastating for us to hear the level of the distress of the young people who came forward in the documentary. That was not what we had heard during the visits. We had heard concerning things about staffing and about the different types of staff, and we had heard concerns about different approaches, but not to that extent.

Emma Harper: If you were to be given more powers, what powers would you want to have?

Julie Paterson: The powers are set out very clearly in the Scottish mental health law review, which was based on three years of evidence gathering from people who use mental health services and their families, various stakeholders, third sector partners in the community and advocacy services.

We would like to have powers in relation to a range of things. There are clearly opportunities, as was recommended in the Scottish mental health law review, for us to take matters to court, if necessary. In the past, when we have needed to do that, we have gone to another partner to do that for us. For example, our partners in the Equality and Human Rights Commission took a matter to court for us with regard to a concern that we had in relation to people's care and treatment. We would like to be able to do that ourselves.

As I said, we would also like to have additional powers in relation to coercion, restraint and the use of community compulsory treatment orders. We have done a piece of work on that in response to the Scottish mental health law review. Community compulsory treatment orders came in in 2005, under the 2003 act. Those orders were meant to support people to stay out of hospital, recover at home and get well. They would then come off the order. However, we and the Scottish mental health law review found that people had been on those orders for 17 years or more, which is coercion in the community. We need to look at how that can be stopped, too, because, unless people are supported to recover and receive the service that they are entitled to, they should not have orders in place to compel them to do things.

There is a range of things in the Scottish mental health law review in relation to which we would like to have the powers to extend our role so that we could be more effective. We also need to be resourced. You will know from our papers that we are a small body. We have a budget of around £4.6 million, and we do our best with the resources that we have, but we would like to extend and expand based on the Scottish mental health law review's recommendations.

The Convener: We will move on to another area of work on which the Mental Welfare Commission has published a report—"Hospital is not home" was published in January this year. What is your perspective on the effectiveness of the dynamic support register in improving visibility and transition planning for individuals with learning disabilities?

Julie Paterson: The Scottish Government commissioned that piece of work to consider the lack of progress—or apparent progress—in relation to people coming home from hospital.

We are very clear that people should not be in hospital unless there is a clinical need for them to be there. It is not the right place for people to be in. We were concerned when Public Health Scotland reported that, at that time, 30 people had been in hospital for 10 years or more. When the Mental Welfare Commission contacted all health and social care partnerships to ask who was on the dynamic support register, we were told that there were 55 people on it. That was within four months of the Public Health Scotland figures, so the numbers are growing.

We focused on people who had been in hospital for 10 years or more. The average stay of those 55 people is 18 years. We are really concerned about the lack of movement and dynamic support planning, despite the dynamic support register and delayed discharge planning. There is quite a significant industry in HSCPs that focuses on delayed discharge, yet people with learning disabilities and complex needs, and people with mental health conditions, are still stuck in hospital.

We found that it is early days in relation to the dynamic support register and the peer support network, which was set up through the "Coming Home" report. I think that the network first met in October 2024. Those two aspects offer hope. The peer support network is so important. We identified that people are getting stuck in hospital because they have very complex needs. There is really good practice in some areas, and, with a national strategic overview, that good practice can be shared nationally and creative solutions can be developed in communities. Solutions exist—the issue is that some areas do not know about them. The peer support network has the potential to make a significant difference in that regard.

The use of the dynamic support register has been quite inconsistent so far. It was unclear who would end up being placed on it and who would not. Likewise, it was hard to know who would be placed on delayed discharge lists. Probably more worrying is that there are people who are not on any list, and they should be. We are quite concerned about that, because there are people who are almost lost and hidden.

Sometimes, an older person might stay in hospital because there is no exit strategy for them. Those people also have a right not to stay in hospital and not to be in hospital if there is no clinical need for them to be there. We also found that there is a lack of dynamic care planning for some of those people. Rather than thinking that creating something for a person who has very complex needs is too expensive, people should be thinking that a dynamic look at services could be more cost effective if that is done as part of the peer support network. The "Hospital is not home" report highlighted all those things, but it followed our “Out of NHS area placements” report as well. There were very similar themes in that regard.

I will maybe pass over to Claire Lamza to talk about our finding that people who were placed outwith NHS Scotland are sometimes forgotten about, because they are in England or in private settings. They have a right not to be there either, but we found that, sometimes, when people were outwith NHS Scotland, their care teams or the host authority would not maintain contact and people would stay there.

The Convener: We might move on to discuss that a bit further. Do you think that the register is effective or not?

Julie Paterson: The register is in its early days. At the minute, the register is not as effective as it could be, because it is so inconsistent as to who is and is not placed on it. Likewise, the peer support network, which is a recommendation of “Coming Home”, was set up only on 24 October. There is time for that to improve. It clearly can make a difference and will make a difference if that co-ordination is in place.

We recognise that health and social care partnerships are extremely busy. They are very busy on their day-to-day work and it is quite difficult to look to your fellow HSCP or one that is quite far away to find out whether some people have similar complex needs and to look at creating a creative solution together. The peer support network will allow that to happen.

As I said, there are really good examples of creative solutions in the community, but not everybody knows about them. That peer support network could make a huge difference. That potential has not quite been realised, but it is there.

The Convener: When you talk about a peer support network, are you talking about interagency working and looking at best practice in particular parts of the country, such as specific local authorities or whatever?

Julie Paterson: Absolutely—

The Convener: Is that as opposed to peer-to-peer support?

Julie Paterson: Yes, you are right. Peer-to-peer support often involves people sharing lived experience, but the peer support network, as recommended in “Coming Home”, is about partnerships and agencies working together to find creative solutions locally for people.

The Convener: Is the Mental Welfare Commission involved in that on-going work?

Julie Paterson: The Mental Welfare Commission is involved in relation to the 55 people identified in “Hospital is not home”—

The Convener: No—I am asking whether the MWC is involved in developing and sharing best practice.

Julie Paterson: No, we are not.

The Convener: Is that because you were not invited to do so, or because you have chosen not to participate?

Julie Paterson: We have not been invited to join the peer support network. I guess that the people who know best what the needs are locally with regard to national strategic commissioning are the commissioners from across health and social care partnerships. We, as the Mental Welfare Commission, would then visit people in those creative solutions that are developed in the community, to be assured that the care and treatment is lawful and in accordance with the standards that we would expect, based on best practice.

The Convener: What improvements do you feel are required to ensure that individuals with learning disabilities and mental health needs who are clinically assessed as being ready for discharge can be helped to transition effectively into community settings?

I do not know whether Ms McGuinness would like to contribute.

Julie Paterson: I will just start by noting that “Out of NHS area placements” highlighted that millions of pounds are being spent across the board in relation to people who are in such placements. If there was a strategic overview of that financial envelope to create something more local, it would make a difference in helping people to transition quicker in a more co-ordinated way to more local areas in Scotland.

I will pass over to Suzanne McGuinness on the social care aspect in particular.

Suzanne McGuinness (Mental Welfare Commission for Scotland): With regard to improvements, as Julie Paterson said, there is currently a lot going on across the piece, and services are facing a lot of barriers and challenges; we see that through our work.

On assessing whether people are ready for discharge, particularly people who are affected by learning disability, it is important to ensure that there is early intervention and discharge planning and that the right resources are in the right place at the right time for people. That is fundamental to improving the outcomes for people.

The Convener: What improvements need to be made? We all accept that such things need to be in place, and the commission is saying that improvements need to be made, but what are those improvements?

Suzanne McGuinness: A lot of improvements need to be made. A lot of joined-up work is going on right now, through the agenda set by "Coming Home" and so on, and we are looking at additional resource. For example, Claire Lamza has conducted a piece of work on out-of-NHS Scotland placements, which found that—at a very conservative estimate—there was a cost of £13 million, through NHS funding, for 59 individuals. That is a lot.

Julie Paterson talked about the peer support network. Everyone is joining up and looking at how we can do things differently and be creative and innovative, but funding is an issue. As part of our role, we also hold end-of-year meetings across every health and social care partnership and every health board, and we hear about pockets of services that are trying really hard to be innovative and creative, but resources are limited, which affects what they can do. Nevertheless, we need to give them the time and space to share that best practice, because they are local and are best placed to decide what is best for people in their areas.

The Convener: Does the Mental Welfare Commission have a view, other than on the need for increased resources and sharing best practice about what improvements need to be made?

11:30

Claire Lamza: That aligns with what we were saying about Skye house in relation to the intelligence. One of the things that Julie Paterson highlighted from "Coming Home" and the follow-up report, and which is highlighted in the information that we collected in "Hospital is not home", which was replicated in the "Out of NHS area placements" report, was that the information that is given to Public Health Scotland is not always accurate. We use that data and get further information on it, but, for example, the data on delayed discharges is gathered differently across Scotland. It comes back to what Julie said about the need for standardised approaches, which would have to come from the Scottish Government and the recommendations that we made at that point.

At the core, if the information is correct, we have the authority and the ability to follow it, as we did with authority to discharge. We need the intelligence and information to check what is happening in the local area, as Suzanne McGuinness was saying, through our area co-ordinators and our end-of-year processes. If we get the information correct, we can follow up either through the individual or through the health and social care partnerships and our links with them. It comes back to knowing that what we have is accurate. At the moment, we are not sure that it is.

To go back to the dynamic support register, when we asked about the 55 people, and as we did for "Out of NHS area placements", we found that the data is not always collected systematically across Scotland and it is not provided in a way that can be followed up to the point that we would want it to be. We want to be able to give that information back to the areas and the partnerships and ask what community resources they are putting in place and what they are doing with discharge planning.

There has to be a progressive continuum, but we also have to get the right information. The commission must be able to access that and have the resources to follow that through.

The Convener: Aside from the better collection of data and increased finances, does the Mental Welfare Commission have any other recommendations for how we can help people with complex needs to transition to community places safely?

Julie Paterson: I will add to what Claire Lamza said. In relation to our work, we have highlighted a range of improvements that are required. For example, in our report on Mrs F, there were huge concerns about the events in relation to that particular death, where there had been a lack of understanding and grasp of the importance of communicating with families and relatives and taking on board their views. That report also highlighted a lack of understanding about risk. We clearly identified that improvements are required not only in that area but across Scotland. When we do a piece of work, such as an investigation, we recognise the learnings across Scotland.

Likewise, the report on Mr E identified that health and social work did not work together, so Mr E fell between the two—social work thought that health was responsible and health thought that social work was responsible. The report was very clear that there was not an integrated approach, despite that being the intention.

The Convener: Does that case relate to delayed discharge from hospital into a community setting?

Julie Paterson: That case does not relate to delayed discharge.

The Convener: I am sorry—perhaps I am not being clear enough. I am talking specifically about what the Mental Welfare Commission recommends to help transition people with complex needs into community settings safely—it is about people who are clinically ready for discharge.

You identified two areas—data and finance. Is there anything else that the Mental Welfare

Commission would specifically recommend that would help to facilitate that?

Julie Paterson: Absolutely. We have already recommended that reform of the Adults with Incapacity (Scotland) Act 2000 is important. The AWI legislation was of its day 20 years ago, but now it is quite clunky. It sometimes prevents people from being able to move from hospital to the community—rightly so, because the safeguarding legislation should be respected, but it could be less clunky. That is a key area, so we look forward to progress on the AWI reform.

Access to the right social care and recognising that there is a range of partners that can provide that social care is very important. Third sector partners are experts in providing social care and rehabilitation in the community. It does not have to happen in the hospital, which is also really important.

Advocacy is critical to supporting people's voices to be heard, particularly for the people who we are talking about. Their voices are often not heard, and they often need some support. They may feel disempowered in hospital settings, and their health condition may mean that they do not have the confidence to speak.

Advocacy is very important, so we are particularly concerned to hear that, in the current fiscal environment, individual and collective advocacy could diminish rather than grow. It would be a huge concern if advocacy were not to be in place for children, adults and older people so that their views are heard and to support them to move outwith hospital to where they want to go, in a setting that is important to them.

David Torrance: Good morning. What do the witnesses think about the progress that has been made to date in implementing the recommendations of the mental health law review? What progress has been made? Let us be open and honest about it.

Julie Paterson: I have spoken at length about that. We welcomed the Scottish mental health law review because, as I said, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 were of their day but are now decades old. They have not kept up with human rights, and there needs to be reform.

We recognise that there were 202 recommendations in the Scottish mental health review and that some will perhaps take up to 10 years to be realised, but others do not necessarily need changes in law and can be acted on much more quickly. As I said previously, there are a number of recommendations that the Mental Welfare Commission would like to see progressed and be considered. Those relate to our role and responsibilities, which we would like to be strengthened to enable us to grow our impact and make us more effective. We are keen for the recommendations to be considered and, if agreed, to be implemented at the earliest opportunity.

David Torrance: Thank you. I have no further questions, because the other questions have all been answered.

Paul Sweeney: I thank the panel members for joining us today. I want to touch on the wider issues regarding key challenges to mental health services. The convener touched on some of the complex cases and asked how services can be better able to deal with those. What measures do—[*Inaudible*.]—to improve care in Scotland's mental health system for individuals with complex needs, including autism—

The Convener: Mr Sweeney, could you repeat your question? We lost a part of it.

Paul Sweeney: Apologies, convener. I am keen to know what measures the witnesses feel should be taken to improve care in Scotland's mental health system for those with complex needs, including autism, acquired brain injuries, personality disorders and dual diagnoses.

Julie Paterson: What you describe is the work of the Mental Welfare Commission. The population's mental health and wellbeing is absolutely important—there is no doubt about that. However, our concern is for people who are at the end of the mental health continuum, who experience severe and enduring mental illnesses.

You referenced acquired brain injury. Our concern is for people who sometimes do not have a voice in the way that other people do to be able to express their views. Those are the people who are most important to the Mental Welfare Commission, because we know that they are some of the most vulnerable people in our society. That is the group of people you described, which is our focus. We need to ensure that their rights are upheld and protected and that we, with services, can support them to ensure that. That is the group of people we focus on throughout the work that we previously described—through our visits to individual people in their homes, in care home settings and in health settings.

You will have noted our previous work in relation to alcohol-related brain damage. We did a piece of work in which we visited a number of people with alcohol-related brain damage, to identify whether their care and treatment was appropriate and whether there was a recognition that people with ARBD can improve their skills and abilities. Legislation is not necessarily required to compel that.

Paul Sweeney: It seems that fundamental problems have been identified in relation to resourcing. In its 2023 report "Adult mental health", Audit Scotland noted that limited and short-term funding across many mental health services is creating additional challenges in addressing staff recruitment issues. That makes it difficult to fill vacancies, because funding is often provided only on a fixed-term basis, which is undesirable to applicants. We have seen that play out in relation to not only third-party services, but core services such as those that are provided at Skye house, where a culture of high staff turnover and a lack of leadership was identified as a key causal factor in the poor performance of that unit.

What long-term strategies are needed to address that short-termism and to deal with the resultant issues with staff recruitment and retention that are currently being experienced across pretty much all aspects of Scotland's mental health system?

Julie Paterson: You are absolutely right. As Suzanne McGuinness has just said, we meet most senior managers in health and social care partnerships annually, and, as Claire Lamza has described, we undertake regular, day-to-day visits, as part of which we speak to nursing, medical and social work staff on the ground.

There is a significant challenge with staffing across the board, whether we are talking about nursing and medical staff or about mental health officers, and that impacts on the care and treatment of the people who are most vulnerable. Mental health officers are a really important safeguard for people. As Claire Lamza has described, not having enough nurses or medical staff can lead to the use of bank or agency staff, who are not substantive within the setting. The use of locum medical staff can lead to a lack of consistency of care and a lack of continuity of care, because there is such a demand for the services. As Claire said, the level of acuity is increasing and our staff group is not increasing to match that. Those are areas in which it has been reported to us that staffing is a challenge, and we need to appreciate that when we visit services, because we need to understand the context.

Likewise, in relation to funding, which you mentioned, we hear from third sector providers, in particular, about the fact that, because they receive annual funding, they lack the ability to plan. Their desire is to have at least a three-year plan rather than fixed annual funding, so that they can plan ahead.

We know that there are significant challenges across the board. As I have mentioned, advocacy is really important for the people you described—the people who are most vulnerable. We need to have services that are sustainable. From our point of view, as the Mental Welfare Commission, we visit, we make recommendations and we focus on the individuals and their experience, but we hear from service providers and commissioners about the challenges that they face in providing the services that we expect them to provide for the people who are most vulnerable, who, the law says, have a right to those services. That includes the right, under sections 25 to 27 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to access assessment for social care services so that they can be supported to leave hospital.

Paul Sweeney: You mentioned health and social care partnerships and integration joint boards. It seems that, every financial year, decisions are made at that level that militate against the creation of long-term value in mental health services. I could rhyme off a number of recent decisions in Glasgow, such as the decisions on Flourish house, the Notre Dame Centre and the Sandyford clinic, that do not chime with the objectives that have been set nationally. There seems to be fragmentation and a lack of accountability across the system when it comes to designing services that are focused on the needs of patients.

With regard to recommendations, what do we need to do to improve a structure that leads to poor data collection, a lack of co-ordination and a lack of accountability?

Julie Paterson: The Mental Welfare Commission's focus is very much on the needs of the people we work with. We are strongly focused on those individuals. As I said, we are not an inspector of services—we do not regulate services—but we hear stories such as those that you have described from the people we meet about the challenges that services face. The issues are interlinked. We ask for the highest level of care for people and for continuity of care, and we hear about the challenges that are faced in relation to finances and funding. Our job at the Mental Welfare Commission is to be aware of that but never to lose focus on the individuals and the care and treatment that they are entitled to under the law.

We appreciate the challenges, and we appreciate that the decisions about funding, structures and organisations sit outwith the commission—it is not for us to dictate how funding should be provided or what people should provide—but we know what services people need in order to live and to flourish. People who have mental health issues, learning disabilities and associated conditions have a right to live the lives of their choosing, to flourish and to receive the support that enables them to do that, and we will continue to make that case.

Paul Sweeney: There will be themes that you gather from people's experiences, and there will be a level of commonality that perhaps drives you instinctively towards certain recommendations. Aggregating patient experience, do you have any insights on common trends or common relationships that enable you to identify what needs to change? Could you at least offer some personal insight on that?

11:45

Claire Lamza: From our local visits, we make more than 450 recommendations. When I look at those reports, the themes seem to be fairly stable. Most of the time, it is about people wanting to feel engaged and have meaningful contact with whoever is delivering the service, including in relation to care planning and discharge planning, and it is about people wanting to be involved in what happens to them. It is also about what restrictions are put in place, which people maybe do not understand or agree with. Individuals who are being cared for can feel that a number of things are being done to them, and we often hear that families and carers are not included in decisions about someone's future—where they will go or what will be available or on offer to them.

The themes remain pretty consistent. The individuals we speak to would like to be heard and would like their rights to be upheld when they receive care and treatment. They would like access to a broader range of, for example, allied health professionals or psychology services. That was picked up clearly in the Audit Scotland report. They also want activities in their community that are meaningful for them and that give them a life that is beneficial to them, as Suzanne McGuinness highlighted.

Environment is another factor that has an impact. Something that has come through over the past few years is that a lot of the environments that people in mental health or learning disability services can access are not fit for purpose.

There are a number of challenges that are raised consistently and repeatedly, mostly around individuals and their carers and families wanting to be heard and involved.

Paul Sweeney: That is helpful. I appreciate your time. Thank you.

Emma Harper: I had some thoughts about the work that I have done previously on eating disorders. I know that the Mental Welfare Commission did an exercise to map eating disorder services in Scotland. We saw an increase in the number of people assessed and diagnosed with eating disorders during Covid. We have had lots of discussions about that and there has been additional funding from the Scottish Government. The eating disorder charity Beat has been really good at engaging with and supporting people through its activities online.

I would be interested to hear about any updates or recommendations following the mapping exercise. What would you say needs to be the number 1 priority in, for instance, referrals, given the eating disorder services that we have across Scotland? For example, in Dumfries and Galloway and in the Borders there are on-the-ground specialists, but sometimes people then need to be referred to Skye house.

Claire Lamza: Again, it comes back to the role of the commission. It would probably be the young people or adults with the most acute experience of an eating disorder and who require secondary care who would come into contact with the commission. They might contact the advice line, so that comes through as casework. At that point, we would advise accordingly and involve organisations such as Beat, which helped us when we were doing the eating disorders work. For anybody who contacted us or asked us about that, we would make the links to community-based services.

On the other side, in relation to the more extensive requirements of people with complex eating disorders, at whatever age, we do more focused work. The mapping exercise and our contact with and visits to services such as the regional eating disorder unit and its equivalent in Glasgow allow us to understand what is happening with the Scottish intercollegiate guidelines network—SIGN—guidelines, how they are being implemented and how they are working.

I am aware of tiers within the eating disorder services—someone might be dealt with under tier 4, or however they work it, and then be handed on to the community-based services. We retain an overarching understanding, but we are focused primarily on when someone is admitted to an environment where they get care and treatment. It goes back to what I was saying to Mr Sweeney. At that point, we would be interested in whether that individual had been made aware of their rights, whether they had been encouraged to develop other strategies and contact other organisations, and whether they had access to all the right care and treatment, such as dietetics, occupational therapy and psychology. We would focus more specifically on those aspects, rather than taking an overarching focus on what was happening with eating disorder treatment across the piece.

Emma Harper: Just before Julie Paterson comes in, I note that there are issues with young people transitioning from in-patient care to community care. Eating disorders affect boys and girls—everybody thinks that they affect only girls, but they do not. I am interested in the community aspects of care.

I am sorry for interrupting you.

Julie Paterson: I will add to what Claire Lamza has said. In May, we issued our updated guidance on eating disorders, which I will send to the committee. A range of people who have experience of using services sit on one of our statutory advisory committees. Its members tell us what work we should be doing for the next business year and what is important to them, and our work on eating disorders would have come from their suggestions. We take suggestions from across Scotland about what we should focus on, because, as Claire said, we know what is important to people only if they tell us. For example, the group might raise the concern that we need to do more on eating disorders in our work on children and young people's units and that there needs to be more learning across the board. That may well come out of our work going forward.

The Convener: We will hear from Ms Callaghan next.

It appears that she is not online.

Stephanie Callaghan: Sorry, convener. I could not unmute myself.

We have talked about families and how it is often difficult to get information when patients are very ill, which makes family support all the more important. Often, families will know the individuals best and will have the strongest desire to ensure that their wellbeing is taken care of and that they get home as quickly as possible. Is there a need to formalise family involvement? Could we have structured interviews in which family input is recorded and reviewed? Are there any other suggestions about how we could listen to what families have to say and act on their input?

The Convener: Your camera must be off, Ms Callaghan.

Stephanie Callaghan: My camera is on.

The Convener: You might need to sit forward.

Claire Lamza: Your timing is perfect, Ms Callaghan. We have just completed our first themed visit for our work on carers, which has been useful. The documents that we have submitted to the committee contain information about the commission's process with the advisory committee. The committee highlighted exactly what you have picked up, which is that we need to hear the voice of families, relatives, carers, unpaid carers and others that are included in the collective terminology. During our themed visit, we consulted a range of carers organisations, in a process that was similar to that which we followed for our work on eating disorders. We are in the process of pulling their views together, and we hope to have a series of recommendations from that work fairly soon.

It is fair to say that some of the stuff that has come through is fairly shocking for us. It is distressing to hear about the experience that carers have had and some of the difficulties that they have faced with their loved ones, as well as about the care and treatment that been provided to them that they have not been informed about. The guidance "Carers, consent, and confidentiality", which we updated recently, highlights some concerns that carers have raised repeatedly with us through our advice line and during our visits and investigations. We have already talked about Mrs F, and we constantly have contact with people to gain an understanding of their issues. I hope that that will come through in the themed visits.

The Convener: I thank the witnesses for their attendance and for their evidence. The committee will continue its work, but please feel free to leave.

Subordinate Legislation

The Human Tissue (Supply of Information about Transplants) (Scotland) Regulations 2025 (SSI 2025/139)

11:54

The Convener: The fourth item on our agenda is further consideration of a negative instrument. The purpose of the instrument is to create a duty for relevant clinicians to notify the Human Tissue Authority if they are made aware that their patient has received a transplant outside the United Kingdom or if they have a reasonable suspicion that specified offences under human tissue or modern slavery legislation may have been committed. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 13 May 2025 and made no recommendations in relation to the instrument. No motion to annul has been received in relation to the instrument.

The committee considered the instrument at its meeting on 20 May and decided to write to the Minister for Public Health and Women's Health to request additional information on it. The committee received a response from the minister on 27 May, which has been published on the committee's web pages.

As members have no comments to make, I propose that the committee does not make any recommendations in relation to the negative instrument. Are we agreed?

Members *indicated agreement.*

The Convener: At next week's meeting, we will undertake periodic scrutiny of the work of the Care Inspectorate, as well as taking evidence from representatives of Food Standards Scotland. That concludes the public part of our meeting.

11:56

Meeting continued in private until 12:09.

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