



**OFFICIAL REPORT**  
AITHISG OIFIGEIL

# COVID-19 Recovery Committee

**Thursday 10 March 2022**

**Session 6**



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**COVID-19 RECOVERY COMMITTEE**

**8<sup>th</sup> Meeting 2022, Session 6**

**CONVENER**

\*Siobhian Brown (Ayr) (SNP)

**DEPUTY CONVENER**

\*Murdo Fraser (Mid Scotland and Fife) (Con)

**COMMITTEE MEMBERS**

\*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)

\*John Mason (Glasgow Shettleston) (SNP)

\*Alex Rowley (Mid Scotland and Fife) (Lab)

\*Brian Whittle (South Scotland) (Con)

\*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Dr Chopra (Mental Welfare Commission for Scotland)

Lawrence Cowan (Chest Heart & Stroke Scotland)

Dr Lynda Fenton (Public Health Scotland)

Rob Gowans (Health and Social Care Alliance Scotland)

Peter Hastie (Macmillan Cancer Support)

Dr Francisco Perez-Reche (University of Aberdeen)

Dr Roger Smyth (Royal College of Psychiatrists in Scotland)

**CLERK TO THE COMMITTEE**

Sigrid Robinson

**LOCATION**

The David Livingstone Room (CR6)



# Scottish Parliament

## COVID-19 Recovery Committee

Thursday 10 March 2022

*[The Convener opened the meeting at 09:30]*

### Excess Deaths Inquiry

**The Convener (Siobhian Brown):** Good morning and welcome to the eighth meeting in 2022 of the COVID-19 Recovery Committee. This morning, we will continue our inquiry into excess deaths in Scotland since the start of the pandemic.

I welcome Rob Gowans, policy and public affairs manager at the Health and Social Care Alliance Scotland; Lawrence Cowan, director of communications at Chest Heart & Stroke Scotland; Peter Hastie, policy and public affairs manager at Macmillan Cancer Support; Dr Lynda Fenton, consultant in public health medicine at Public Health Scotland; and Dr Francisco Perez-Reche from the institute for complex systems and mathematical biology in the school of natural and computing sciences at the University of Aberdeen. Thank you for giving us your time and for your written submissions.

This is the second of two sessions that we are holding to take evidence from stakeholders as part of our inquiry before we hear from the Cabinet Secretary for Health and Social Care on 17 March.

Each member will have approximately nine to 10 minutes to speak to the panel and ask their questions. If you would like to respond on a particular issue that is being discussed, please type the letter R in the chat box and we will do our best to bring you in. I am keen to ensure that everyone gets an opportunity to speak. I apologise in advance that, if time runs on too much, I may have to interrupt members or witnesses in the interest of brevity.

All our witnesses are appearing remotely. I ask you to briefly introduce yourselves, starting with Rob Gowans.

**Rob Gowans (Health and Social Care Alliance Scotland):** Good morning. I am policy and public affairs manager at the Health and Social Care Alliance Scotland.

**Lawrence Cowan (Chest Heart & Stroke Scotland):** Hi there. I am director of communications at Chest Heart & Stroke Scotland.

**Peter Hastie (Macmillan Cancer Support):** Hello. I am policy and public affairs manager at Macmillan Cancer Support.

**Dr Lynda Fenton (Public Health Scotland):** Good morning. I am a consultant in public health medicine at Public Health Scotland.

**The Convener:** Finally, we have Dr Francisco Perez-Reche. I hope that I pronounced that correctly.

**Dr Francisco Perez-Reche (University of Aberdeen):** Hello. Your pronunciation is great. I am a senior lecturer at the University of Aberdeen.

**The Convener:** Thank you. We turn to questions, and I will begin. Some of the previous witnesses in our inquiry have said that, at this stage, it is still very difficult to draw any conclusions on excess deaths and that we might have to wait a considerable time to do that. However, the consultation response from Chest Heart & Stroke Scotland says that, in the past year, there have been

“1,389 more ... deaths at home from heart disease and stroke and 679 fewer in hospital”.

That could be due to people’s reluctance to visit a general practitioner. The response states:

“Latest data shows 25% of people saying they would avoid contacting their GP at the moment.”

Those statistics are very worrying. Lawrence, would you like to comment further?

**Lawrence Cowan:** You are absolutely right. The figures are concerning. I agree with your previous witnesses who said that the full magnitude of the pandemic will become known only over a longer period. We are talking about excess deaths, but we also need to consider whether cases are more complicated and there is a greater impact on people’s everyday lives because they have sought help later, and whether that will have a long-term impact on our health service that lasts more than just a few years. This may be something that will be with us for a long time.

The worry for us is that the pandemic has created a dangerous domino effect. There are a number of reasons behind that, given the figures that we have seen. First, there is the healthcare hesitancy that you talked about in relation to the number of deaths at home.

In addition, emergency admissions and presentations are still lower than average. Whether that is related to fear of coming into contact with Covid or to the view, “The NHS is overrun. I’ll be okay—I’ll see if things get better later,” that is very worrying for us. We need to address that.

We also need to take into account the wider impact of the things that we had to do because of the virus. Lockdown had a big impact in increasing isolation and loneliness. According to Scottish

Government figures, 48 per cent of people say that they feel isolated and lonely. There is also the wider impact of policy priorities before the pandemic, which is worrying for us, too.

It is a question of making sure that the whole system is properly integrated. That system includes charity services such as ours. We support people who leave hospital to stay well and happy at home, which has a wider impact on their health and wellbeing, which, in turn, has a positive impact on services and pressures in the system.

We are concerned by a mix of things, which are all interlinked. The initial figures are quite concerning and point to big issues that need to be addressed.

**The Convener:** Thank you. I agree with you. It is extremely important that people get back the confidence to visit their GP and do not ignore warning signs.

My next question is for Dr Fenton of Public Health Scotland and Dr Perez-Reche. What is your interpretation of the excess deaths data?

**Dr Fenton:** I think that the excess deaths measure is very helpful and has been a robust measure of the overall mortality impact of the pandemic period, through Covid-19 and other causes.

We can see three phases of excess mortality across the pandemic, which had slightly different causes. In the very early phase, in March and April 2020, there appears to have been a short period of a few weeks when there were deaths that are likely to have been due to Covid-19 but which were not certified as such because of testing or diagnostic difficulties. I think that that was a fairly short-lived issue.

The excess mortality in the period over the winter of 2021 was driven largely by Covid deaths.

Perhaps the most concerning period is that from around May to December 2021, when there was a consistent period of excess mortality, about half of which was non-Covid mortality. That excess mortality occurred across a range of causes of death, but there were substantial contributions from circulatory causes. I can go through the other group in a bit more detail, but it is likely to consist of mortality from external causes, such as drug-related deaths and liver disease. That excess mortality occurs across a range of age groups—it is not concentrated in one particular cause or age group.

Since January, there has been some improvement. We have not seen an increase in excess deaths over the past few months of reported data from National Records of Scotland.

My interpretation is that this is a substantial issue, which involves a range of causes of death and affects a range of age groups. In view of that breadth, it is likely that there will be health service factors and factors that are related to the determinants of health. As Lawrence Cowan mentioned, a lot of things have changed as a result of lockdown: people's material circumstances, their social isolation and their access to services. We need to look at what is driving health and ill health in the first place.

To reflect on your first question a little, I think that it is possible to draw some conclusions at this point. Our understanding of the full extent of the impact will grow over time, but we can take what we know about the determinants of health, about health in the pre-pandemic period and about what has changed across the pandemic to draw some initial conclusions.

**Dr Perez-Reche:** My conclusions are very much in line with what Lynda Fenton has just set out.

I looked into the variability of the excess deaths in addition to the expected value or the mean value. I agree that the main concern is that there was a consistent excess of non-Covid deaths in the second half of 2021; before that, there were periods of excess deaths and periods of deficit. It is important to bear those periods of deficit in mind; it might be that some people unfortunately died of Covid before the time they would have died of another disease. That is something that seems to come out from the data.

There was certainly a period in 2021, from July or so, when there was a consistent excess of non-Covid deaths. That is statistically robust. Sometimes, you might find one result or another depending on how you compare things. However, in that case, it is statistically clear that there was a consistent excess of non-Covid deaths. One interpretation could be that some people got to a point where their non-Covid-related disease was already at a critical stage and it took a year and a half or two years for that to appear. That is worrying, because it means that something was building up until there were those excess deaths.

In January 2022, the data is not that clear whether there was an excess or not. There is not a statistically significant deficit or excess, so it looks as though, at the moment, we are back into normal times in relation to non-Covid deaths.

My impression is that it will probably fluctuate, because there is a balance between the number of people who have died before their expected time and then the deficit of non-Covid deaths. It might be that the second half of 2021 was one of those times when there were more deaths than expected and now we might go through a time when there might even be a deficit. However, given the

backlog, I think that there will be more periods of excess deaths in the future. That is more or less my interpretation.

**The Convener:** Thank you very much for your valuable input. We will probably wait to see the data from this year a bit further down the track.

**Murdo Fraser (Mid Scotland and Fife) (Con):** Good morning. I would like to follow up on the convener's questions, both of which are important.

On the data question, the submissions from Chest Heart & Stroke Scotland and Macmillan Cancer Support both make the point that there is anecdotal evidence of people who have been suffering from heart disease and stroke in one case, and from cancer in the other case, presenting later at hospital but, so far, it is only anecdotal and there is not enough data.

First, can Peter Hastie from Macmillan Cancer Support elaborate on that? Also, when would you expect the data to appear? Then perhaps I can go to Dr Francisco Perez-Reche, whose paper suggests that there is a bit more concrete information available rather than just anecdotal evidence.

09:45

**Peter Hastie:** The figures are starting to come through. We know that there were excess cancer deaths in 2020 and 2021, but we do not yet know how significant those figures are. Naturally, people who died of Covid might have gone on to get cancer, so, as Dr Perez-Reche has said, the figures can fluctuate.

However, there is no debate whatever that cancer patients are presenting later. Indeed, Macmillan GPs, nurses and our extensive benefits staff the length and breadth of Scotland are saying that, which, as we know, means more advanced treatments, poorer prognosis and more likelihood of death. The cancer system was not good before the pandemic, and all the problems that we knew existed have been exacerbated by it.

The data that we know is the most recent staging data, which showed a reduction in stage 1 diagnosis. The fact is that, if you are going to get cancer, you will want it to be diagnosed as early as possible. In 2020, there was a reduction in stage 1 diagnosis; we expect to see the same for last year, but we will not get that staging data until later this year. In April, we have cancer incidence and cancer survival statistics coming out, which might help us and, later in the year, we will have more cancer mortality and staging data, which might help us, too.

There is one piece of evidence in which the numbers are crystal clear. When the Scottish Government suspended the cancer screening

programmes in March 2020, it said that, per quarter, that would mean 248,000 fewer bowel kits being sent out, 46,000 fewer breast-screening examinations and 101,000 fewer cervical screenings. Because the suspension lasted six months, that meant that there were 500,000 fewer kits sent out, 100,000 fewer breast screenings and 200,000 fewer cervical screenings. We know from the Scottish Government's own figures that cancer would have been detected in around 850 people in each quarter—or 1,700 diagnosed in the first six months of Covid. It is plain what will be happening with that cohort.

One real concern is that there is still a six-month delay to the bowel-screening programme. In other words, when you turn 52, you do not get your kit until you are 52 and six or seven months, and the same when you turn 54, 56 or 58. That backlog and that delay have continued. The situation will right itself eventually—once everybody has done the test, we will back in a two-year pattern—but long-term issues such as the lateness of cancer diagnosis and poorer prognosis will last for years.

**Murdo Fraser:** Some of the statistics that you have given us are stark and, as a gentleman of a certain age, I am in that category of those who have missed their bowel-cancer screening. I therefore recognise what a problem this is.

In your submission, Dr Perez-Reche, you are a bit more definitive than citing just anecdotal evidence; indeed, you are quite clear that there is evidence of patients presenting with more acute conditions. What have you found?

**Dr Perez-Reche:** That is a tricky question, given the data that I had access to. I tried to make the most of that, and I realised that, if you look at the delay between with hospital admissions and deaths, you will see that, at the beginning of the pandemic, the delay was between two and 15 days. Again, I point out that the data is limited, but if we look at later periods, when there were more excess non-Covid deaths—when I talk about excess deaths, I mean excess non-Covid deaths—the data seems to support the idea that there is a shorter delay between admissions and deaths. That might be due to many factors, including deaths not being registered at the same pace, and it might have nothing to do with more acute disease and so on.

There is evidence that people who died in the late stages of the pandemic—the second half of 2021—died in a shorter time. One would need more data to see whether that is the case, because my evidence is not so strong. I would ask for more data on how long it takes for someone to get admitted to hospital or get diagnosed and die. It would be great to have that measure, but I could not find it anywhere.

The other measure was the proportion of deaths by admission—that is, what is the proportion of people who are admitted to hospital and die? Again, that is based on limited data, but it shows that we have been above the normal trend. That is in figure 3 in my report. In the period when there was an excess of non-Covid deaths in 2021, it looks like the proportion of people who died after being admitted to hospital is higher. I thought that that could also indicate a signature of more acute disease. It would be great to have more detailed data in order to be more solid on that.

**Murdo Fraser:** If there is time, I would like to ask another question following up the convener's first line of questioning on access to GPs. I direct my question initially to Rob Gowans from the Health and Social Care Alliance Scotland. When we speak to the British Medical Association about access to GPs, it assures us that GPs are working harder than ever, that GPs are still seeing patients and that there has never been a problem for patients getting to see a GP. However, the evidence that we hear from people such as you—it is in your written submission—is that the public are concerned that people have not been able to get GP appointments or have been reluctant to approach a GP. How much of that is a supply issue? In other words, has it been difficult to get appointments with GPs because of Covid restrictions? How much is it a societal and cultural issue whereby people have not sought GP appointments, because they are concerned about leaving the house and catching Covid, or because they feel that there has been so much emphasis on Covid that they do not want to distract GPs from dealing with Covid patients to deal with what they might view as a more trivial matter? Do you have any insight on that?

**Rob Gowans:** There is a range of issues to consider, some of which you have mentioned. During the pandemic, the impression was created for many people that they should not go to the GP unless they had Covid, and that Covid was the priority. People found it difficult to get appointments in the early stages if they did not have Covid. We recently did a survey of people's experiences of accessing GPs during the pandemic. The initial findings are that only around a third of people felt that their expectations were not met when they called the GP surgery.

Experiences included things such as people feeling uncomfortable when discussing issues with receptionists who were exercising the triage function, and preferring to speak to the GP. We found that phone appointments have worked well for some people, but others were concerned about how effective they were.

Similarly, although digital services such as NHS Near Me are suitable for some people, they are

more difficult for people who do not have access to a device, do not have a good internet connection or do not feel comfortable coming forward in that way.

There is a mix of issues. One relates to supply, particularly in the earlier parts of the pandemic. Another relates to being able to cope with demand, which might be caused by people putting off going to their GP and then presenting in a worse condition.

**Alex Rowley (Mid Scotland and Fife) (Lab):** The Health and Social Care Alliance highlights that health inequalities have widened during the pandemic. In its submission, Chest Heart & Stroke Scotland says that cases of poor diet, lack of exercise and isolation all increased during the period. What action does the Government need to take? Is the data available to demonstrate clearly that people from lower socioeconomic backgrounds have poorer health and that the impact on them has been greater?

In relation to Chest Heart & Stroke's submission, a wide and varied range of public services are out there; we are not just talking about health services. Is any planning taking place? Should specific planning be done on inequalities and deprivation in order that we can recover from that?

**Lawrence Cowan:** You are right that the impacts of the pandemic, including economic and societal impacts, have been more marked in areas of deprivation. The British Heart Foundation produced a report recently on non-communicable diseases that showed that there have been significant increases in unhealthy behaviours, such as eating unhealthily and smoking, and an increase in isolation and loneliness. Those unhealthy behaviours have an impact on people's risk of stroke, heart disease and chronic obstructive pulmonary disease, which are among the main conditions that we deal with in Scotland.

Are services joined up as well as they should be? The clear answer is that they are not. That goes back to a point that I made earlier: some of the problems that we see now have been exacerbated by the pandemic, but those problems existed before the pandemic.

The model that has been used for health has been very much a medical one. In relation to the services that we provide, when we say that we keep people happy and healthy at home, that is about helping people to adjust to life after a life-changing event such as a heart attack, a stroke or a COPD diagnosis, but it is also about improving their exercise, diet and wellbeing. Those simple interventions can have a massive impact. We do that work across the country, including in areas of deprivation. The interventions can have a



significant impact on a person's health, which has a knock-on positive impact on the health service.

We have not joined up such work properly; it needs to be integrated a lot more readily. What do I mean by that? We need to make the diagnosis pathway and the referral pathway to services such as ours very clear. That works in some health board areas; in other areas, the pathways do not exist. The process needs to be a lot easier.

At the moment, we are doing a lot of partnership working with health boards, which is really positive. However, we are doing the running on that and it should be an automatic system, so that when a patient is discharged from hospital, they are discharged automatically to a wealth of services. That happens in some areas, but not in others. That needed to be addressed before the pandemic, and it must be addressed now. It is partly about providing a valve to release pressure on the health service, but it also improves people's health and, most markedly, it improves it in areas of deprivation. That is a big priority for the future.

10:00

**Alex Rowley:** That is helpful. Rob, on the question of the widening inequality gap, what needs to happen to bring services together to work together?

**Rob Gowans:** A number of things need to happen. We know that the number of excess deaths in the most deprived areas is twice what it is in the least deprived areas. We need better data and, in particular, data that is disaggregated by age, sex, race and other aspects in order to understand the impacts fully. We need to take an equalities and human rights based approach to ensure that people's human rights are at the heart of healthcare access so that health inequalities are tackled. Holistic care and support are really important, including the house of care model, which I particularly recommend.

As Lawrence Cowan suggested, we need the involvement of the third sector, which has a key role to play in supporting healthcare. It should be an equal partner, so the issues to address are underfunding and undervaluing of the third sector. It should be allowed to be a meaningful and valued partner in the design and delivery of care and support. That would require ensuring of adequate funding for the sector, as well.

**Alex Rowley:** I think that Dr Fenton wanted to say something on that.

**Dr Fenton:** Thank you for the opportunity to come in while we are on the topic of health inequalities. I am keen to highlight that we know well that in Scotland there are substantial socioeconomic health inequalities that preceded

the pandemic. They worsened not only throughout the pandemic period but in the immediate period running up to it.

Unfortunately, from around 2012, overall life expectancy stopped improving in Scotland—the same happened in a number of high-income countries. The stalled improvement in mortality was much more acute in populations in our more deprived areas, to the extent that mortality rates were increasing in the most deprived areas in the run-up to the pandemic. That has been overlaid by the situation in which Covid mortality was 2.5 times higher in the more deprived populations. That begins to speak to some of the underlying factors that are common across Covid and non-Covid health that influence people's wellbeing and their ability to cope with challenges.

On action, we want income support that people can access. We welcome the welfare support that has been available throughout the pandemic through furlough and the universal credit uplift, but we recognise the challenges that are likely to exist now that people's income has been hit hard and the cost of living is going up. That will limit the choices and opportunities that people have and will further straiten their material circumstances. The consequent psychosocial impacts of that are likely to play out across the current period and the period ahead.

We want a focus on our other universal services outside health, including education, early years support and housing, and on improving places and spaces for people. That brings us to thinking about a "health in all policies" approach. We strongly advocate for that in the Covid recovery period, so that we think about how we can address wellbeing and inequalities across a range of policy areas.

**Alex Rowley:** Okay. Thank you. I will bring in Peter Hastie on that question, and I have another question for him. You gave the good example of bowel testing, in which there is now a delay. Is Covid still having a major impact in hospitals, or can we see a shift to non-Covid conditions being seen as a public emergency? In relation to bowel cancer, the importance of bowel testing seems to be quite clear. What other actions do we need to consider for the national health service in Scotland, specifically in relation to cancer?

**Peter Hastie:** Health inequalities remain at the heart of everything that Macmillan Cancer Support wants to do. If a person lives in a deprived area in Scotland, they are more likely to get cancer, to be diagnosed later and to die. I cannot see how it would be possible for the pandemic to have improved that situation.

Given that the committee is looking into excess deaths, it would be great if it could start to look into palliative and end-of-life care. We know that there

has been a dramatic shift, but what does that mean? Some families might have a household that can cope with that situation, but many others—particularly in the poorest areas—will not be able to cope. We still do not have a palliative and end-of-life care strategy in Scotland—the previous one ended 14 months ago. It is key that we understand the excess deaths and what has happened to patients during the pandemic. Obviously, Macmillan Cancer Support would offer input to that in relation to cancer.

It is clear that the pandemic is not over. Yesterday, the weekly figures from Public Health Scotland showed that more than 4,000 NHS staff were off because of Covid, and hospital cases are rising again. We are really concerned that we are going into yet another wave, and we have only just come out of the omicron wave. It is really hard to see how we will continually catch up with cancer backlogs as they build up each time.

Macmillan Cancer Support desperately needs modelling of the cancer workforce to see how we deal in particular with patients who come through at later stages. They need far more treatment, including more end-of-life treatment. There are workforce issues, so we look forward to the publication of the delayed Scottish Government workforce strategy, which must talk about modelling the cancer workforce. It was not good before the pandemic, and we are deeply concerned about the long-term trends.

What can we do to retain staff in the workforce? We know that staff are burned out. Can there be more learning and development for staff to learn about cancer and to move up grades? We have a wonderful cancer workforce, but it needs to be supported in respect of learning and development and time off for training in order to keep people motivated and keep them in their posts.

There are huge issues but, as suggested, health inequalities remain at the centre of what Macmillan Cancer Support tries to tackle in Scotland.

**John Mason (Glasgow Shettleston) (SNP):** We have covered a bit of ground so far. To start, I have a general question about the balance between Covid and other conditions. Have we, as a society, put too much emphasis on Covid and taken our eye off all the other issues?

**Dr Fenton:** Given that we have faced a novel organism with high transmissibility and high virulence, it was appropriate that we approached it on an emergency footing, that it was a priority for not only Public Health Scotland but across a range of public agencies, and that it has dominated our response over the initial period. Public Health Scotland has recognised throughout that there would be a balance between harms and benefits in how we approached it. Part of our role is to

balance the evidence and to try to provide information to inform decision making.

As I have mentioned, there were substantial pre-existing health issues in our population, and we are now seeing, in excess mortalities, those issues continuing to play out and be exacerbated.

I would support a focus on the underlying determinants, but it is difficult to view the situation as a direct competition between Covid and non-Covid causes because there are many commonalities in the factors that will influence health and outcomes across both sets of conditions. The very fact that we see such substantial inequalities in Covid mortality shows us that if we can do something about people's pre-existing health, and their ability to control their lives and their employment, perhaps there would be much lower Covid mortality, as well as improved health in general.

**John Mason:** Let me press you on that. I take the point that there are big inequalities between those who are better off than those who are less well off and so on, but within a particular group, whether that be the better off group or the less well off, did we put too much emphasis on Covid? Should we have been looking at cancer in richer people and cancer in poorer people?

**Dr Fenton:** Is your question specifically about the allocation of resource within the NHS?

**John Mason:** Yes.

**Dr Fenton:** Public Health Scotland's role is focused on prevention and early intervention and less on the allocation of resources within the health service.

**John Mason:** I understand that.

**Dr Fenton:** I therefore do not have detailed information about clinical decisions that were taken within front-line services.

**John Mason:** Thank you. That is helpful. Mr Cowan would like to come in.

**Lawrence Cowan:** I totally agree with what Dr Fenton said. It is a debate that will need to happen within the health service for a long time. How do we—[Inaudible.]—My microphone was muted.

**John Mason:** We lost you for a moment there.

**Lawrence Cowan:** I agree with what Dr Fenton said. This could be a more consistent challenge for health service planning because the virus will still be with us and we will still have to manage its impacts while improving how we deal with existing serious conditions such as chest, heart and stroke.

To answer your question about focus, the focus was quite rightly on a virus that was ready to overwhelm society and the NHS. We now have

the space to think about what we would need to ramp up to make sure that there are not more deaths from things like stroke, or indeed more people experiencing disability in the community because they present late. That is why we need to reinvigorate the FAST campaign and other awareness campaigns to remind people that they need to get urgent treatment for stroke. We now have that space and we need to make those calls to remind people that they need to seek urgent treatment for stroke and remember what its symptoms are.

**John Mason:** I am sorry; I have to move on to somebody else. Mr Gowans would like to come in.

**Rob Gowans:** On the balance between Covid and non-Covid treatment, the pandemic is certainly not over, especially in terms of the impact that people are feeling and the need for healthcare, particularly among people who were shielding, or still are. Equally, as was said earlier, people faced significant barriers to access to healthcare during the pandemic, and that situation has not fully recovered.

It was not necessarily wrong to focus on Covid, but, equally, people's health has worsened as a result of reduced access and, in some cases, that has, unfortunately, reduced their faith in the NHS. It is important to increase our efforts in both areas.

10:15

**John Mason:** Dr Fenton, I was interested in a couple of points in your paper and I would like you to expand on them. You say:

"Cancer is one of the few conditions where staging is routinely carried out and recorded. It is therefore presented as a proxy"

that might help our understanding. I do not understand why we are using cancer as a proxy.

You also mention the number of years lost, or YLL. I am not familiar with that phrase, although I assume that it is commonly used in some circles. Should we focus more on that kind of thing rather than on the number of deaths or some of the more simplistic measures?

**Dr Fenton:** On the point about cancer, when we try to understand the point in a disease at which people seek care and the impact that earlier or later presentation has on the outcome, cancer is clearly important in its own right, as one of the main causes of mortality and morbidity. It is also useful because we have quite rich data around it, as well as a clinical staging system. At the time of diagnosis, patients are given a stage between 1 and 4 that describes the spread of the cancer. For other conditions, such as coronary heart disease and angina, there is not such a consistent way of describing the point that someone's condition has

reached when they present. Cancer staging is also closely linked to the anticipated survival and treatment response. It provides us with a way of tracking into the post-pandemic period whether those things are deviating from what we would have hoped for before the pandemic. Cancer as a condition will function as a kind of tracker of this delayed presentation issue.

I agree that we could broaden our use of measures. Years of life lost is a measure that describes healthy life expectancy. Life expectancy is a summary measure of deaths across the population, which is helpful for comparisons of time and place and remains important as an overall measure. Healthy life expectancy sits alongside that, but provides an assessment of the years of life spent in good health and sums those up into this summary measure. Healthy life expectancy is in the national performance framework indicators, and it will be helpful to continue to measure it. Unfortunately, it was also falling in the pre-pandemic period, and will continue to do so.

There are some other measures that we could consider as ways of monitoring. For example, NRS recently published the avoidable mortality measure, which concerns specific conditions that are thought to be amenable to healthcare. There is a range of other options.

**John Mason:** Thank you.

**Brian Whittle (South Scotland) (Con):** I want to follow on from John Mason's questions about data.

In my time on the Health and Sport Committee in the previous session of Parliament, before Covid, one of the recurring themes was that we seem to be behind the curve in relation to not only how we collect data but how we analyse it. That has been exacerbated greatly by the pandemic. Do we now have an opportunity to reset how we collect data, to the benefit of the healthcare system, and use that data to drive Government policy on health?

**Dr Perez-Reche:** It is a good opportunity to make relevant data available more regularly. Now, after all, perhaps there is an awareness of how important it is to have good, up-to-date data.

Something that might help in that respect is consultations with data scientists such as me or professional researchers to see what kind of data would be needed. Sometimes, the connections are not that clear. Someone might come up with an idea about what kind of data it would be good to have.

That might not be data. What I mean by that is to do with the formulation of how data is shared or collected and so on. It would be good to

reformulate that in consultation with people who will ultimately analyse it. That would help. Maybe it has been like that in the past and I was not aware of it.

**Brian Whittle:** In the previous parliamentary session, there was a recurring theme about how we could improve the way in which we collect and analyse data. To take that a stage further, I was interested to hear what Lawrence Cowan said about inequalities and how access to the work that his organisation does around group physical activity has been restricted because of Covid. That is more likely to happen in areas that are lower in the Scottish index of multiple deprivation. I am thinking about the collection of data on physical activity throughout the pandemic and the impact on excess deaths related to that. Using that data alongside or cross-referencing it with the health data that we are talking about would probably help us to integrate the third sector offering into NHS offerings. Lawrence Cowan, do you have an opinion on that?

**Lawrence Cowan:** We need to see a lot more of that data. We have a lot of data about the impacts of physical activity levels on people's general health and the lack of physical activity opportunities in areas of deprivation. There is also a wider issue about making sure that the services available are meeting those needs.

A key point is that data presentation is one thing and data collection is another. The sharing of patient data is at the centre of integration, and that is not happening. To put it politely, it is very difficult for a third sector organisation to work with the NHS without a data sharing agreement. That needs to change, because that is what is standing in the way of interventions being more smoothly and widely available, which could reduce pressure in our NHS and help staff to do their work.

Another data issue is about making sure that data sharing is a lot smoother and that data is more easily accessible to everyone who is helping people's wider health and wellbeing.

**Brian Whittle:** The question that you have raised about who owns the data and therefore how it can be used that has exercised the Health, Social Care and Sport Committee and its predecessor for a while. We will not get into that in this committee.

Lynda Fenton would like to come in.

**Dr Fenton:** I recognise the need for on-going development of the collection of healthcare data. It might be helpful to recognise the opportunity that the pandemic gave us to develop some of our data presentations. We have made big strides in making data available in a more timely way, not just through the Covid daily dashboards, but through our wider impact dashboards, which

provide monthly data on the pandemic's impact on health services.

One thing to highlight in relation to restart and recovery is the importance of our health surveys, particularly the Scottish health survey, which is one of our main sources of information about people's health and wellbeing and does not rely on healthcare statistics. Bringing those back to a status that is comparable to their status before the pandemic would be really valuable. This year's census will be invaluable in helping us to begin to know our population accurately, such as where they live, and to understand their needs. The surveys will be very helpful.

**Brian Whittle:** I will finish off my line of questioning by tying up what Dr Fenton has just said and Lawrence Cowan's comments about the need to share data. This is probably a difficult question to put to you, Dr Fenton, but do we have an IT system that enables us to collect and analyse the data?

**Dr Fenton:** There is a range of IT systems across our health service. Some of those support collection and analysis more easily than others. We do not have a single system that easily supports that, and it is certainly the case that some areas would benefit from the development of such a system.

**Jim Fairlie (Perthshire South and Kinross-shire) (SNP):** I want to go back briefly to Murdo Fraser's question to Dr Perez-Reche about patients either being unable to access a doctor or choosing not to go to a doctor, because of a belief that the NHS could not allow it. What is your understanding of that? You seem to be saying that although the data is not definitive, it supports the view that the period from diagnosis to death is shorter as a result of people not seeing their doctor. I hate to be so blunt, but, unfortunately, that is what I am asking about. Is there no way of telling from your data whether death could have been avoidable had the period between diagnosis and treatment been shorter? Is that correct?

**Dr Perez-Reche:** Actually, my measure was from admission to death, not from diagnosis to death.

**Jim Fairlie:** My apologies.

**Dr Perez-Reche:** That data might exist, but I did not look into that.

There would be ways of seeing whether deaths could have been avoidable, but that would require mathematical modelling. It would not be just a matter of someone having an idea about what that would be—they would have to carry out the work. The best way of considering the issue would be to get data on the length of time from admission to death and look at that over several periods. I think

that the data, rather than the modelling, would be more definite.

**Jim Fairlie:** Thank you.

Dr Fenton, my next question is for you, although I appreciate that you might not have the answer. My previous question has sparked a train of thought. How has people's inability to get access to treatment after diagnosis contributed to excess deaths? Has that been a contributory factor?

**Dr Fenton:** That is one of the areas where we are still gathering information. With cancer, for example, the main issue was people not presenting with symptoms or not being identified through screening. I think that the evidence from the cancer data is that, certainly in 2020, once people presented, the time from their diagnosis to their beginning treatment was the same.

We can hypothesise from what we understand. With conditions such as coronary heart disease, a patient might present to their GP with chest pain that occurs when they exercise. If people decide not to take that problem to their GP, they will not be started on the medications that help prevent that condition from progressing. It might then become more severe and lead to a heart attack sooner than would have been the case had they gone to their GP when the problem was milder and had they been started on medications that would have prevented disease progression. We can use our knowledge about the impact of secondary prevention—prevention through healthcare services, for example—to understand the impact that delays in seeking care might have had.

10:30

**Jim Fairlie:** So there was no delay in people getting treatment after a diagnosis had been established.

**Dr Fenton:** The 2020 data for cancer shows that, once patients had been diagnosed, they progressed to treatment as they would have done before the pandemic. The majority of issues were about patients being diagnosed initially, either by presenting to services or through screening.

**Jim Fairlie:** Okay. Would any of the other witnesses like to come in on that question?

**Peter Hastie:** Earlier, I talked about the screening issues, including the on-going issue in relation to bowel cancer. As Dr Fenton has said, our health services are superb once someone is in the system and being treated for cancer, but getting people into the system has been the problem. That has been due to a mixture of issues, including screening programmes not existing and the various reasons why people did not go to their GP. Sadly, a lot of people are

diagnosed with cancer at accident and emergency departments, and the fact is that people were reluctant to come forward at the start of the pandemic.

Figures that came out a couple of weeks ago show record cancer diagnostic waiting times. However, those waiting times do not apply just to cancer; there are also record waiting times for people who are trying to get an endoscopy. The problem comes at the beginning of the cancer journey; once the decision to treat has been taken, the 31-day target is normally hit in Scotland.

The issue is people coming into the system with a red flag and their being flagged up via a GP, via screening or via another condition that they present with at an A and E department. It is about whether the diagnostics can be done so that the decision to treat can be taken and the treatment can begin. During the early stages of the pandemic, a lot of decisions were taken about people not coming in for chemotherapy and radiotherapy. We understand why that happened, but those decisions were very difficult.

**Lawrence Cowan:** As has been said, healthcare hesitancy, which we have discussed quite a lot this morning, has had an impact. It is essential that strokes, in particular, are treated quickly. As for the performance of the health service, there is no doubt that professionals on the ground have been moving heaven and earth to make things happen during the pandemic.

The stroke care bundle is a bundle of targets specifically for ensuring that people get treated quickly when they arrive at hospital with a suspected stroke or a transient ischaemic attack, which is also known as a mini stroke. Those targets were being missed before the pandemic, and the data shows that, early in the pandemic, they were missed again. We need to keep an eye on that. It relates to the question about the wider impact of the pandemic with regard to, for example, deaths from strokes and more disability from strokes, and that information will soon be coming through from the stroke care audit. Indeed, the issue was identified as something to flag up and be worried about in the previous stroke care audit.

**Jim Fairlie:** Dr Fenton, following up on that process, I note that, in its evidence, Health and Social Care Alliance Scotland states that access to doctors was an issue. Doctors have talked to the committee about the enormous strain that they are under, but there seems to be a perception among the public that people cannot get to see their GP. Clearly, it has been necessary for processes to change in order to deal with the pandemic, but will people just have to accept that getting access to a GP will have to be done differently?

**Dr Fenton:** Primary care is fundamental to delivering effective and efficient healthcare, so I would very much advocate for investment in our primary care services. I think that determining how those services best meet the health needs of the population is almost a conversation that needs to be had with the population, because we need to understand those healthcare needs and meet them appropriately.

The pandemic has led to major shifts in how we provide healthcare. There will be beneficial learning from some of them, while others will have had adverse effects. However, there is an opportunity to review how we provide services and how they are best meeting need.

Before the pandemic, the inverse care law in primary care was substantially in operation, with the people in the most deprived areas having the worst primary care provision per head of population compared with those in the least deprived. It is of fundamental importance that we appropriately match our primary care offer to the health needs of the population.

**Jim Fairlie:** Having listened to all the evidence, can I conclude, then, that we clearly still have a major problem with the disparity between richer and poorer areas, because the health inequalities are still there; that the service, once a person got into it, was actually as good as it was prior to the pandemic; that we might have to change the way in which primary care is delivered; and that our screening levels have to get back up at least to where they were before—if not to a better level—to allow us to get out of the current situation? Is that a fair assessment of what you have told us today?

**Dr Fenton:** I think that those are reasonable points, but I would add the need to act on the drivers of ill health. We needed to do that before the pandemic, and we still need to do it. We need to act on the fundamental determinants of health in terms of people's opportunities and chances to build a healthy life.

**Jim Fairlie:** Right. Would you like to come in on that as well, Lawrence?

**Lawrence Cowan:** Yes. On GPs, it is fair to say that patients have absolutely benefited from some of the things that have been done differently. At the moment, however, the emphasis is on GPs doing things differently to manage pressure rather than to improve the situation.

For us, the issue is really making sure that we can take the pressure off GPs with some of the services that we offer. Long Covid, for example, is a condition that is putting a lot of pressure on general practice, and the similar problems that we are seeing in matching up and sharing data in primary care are exacerbating that pressure. On a

policy level, we need to ensure that we do things differently to improve services rather than to manage pressure.

As for service delivery, targets for stroke, in particular, have been missed time after time. When you get to hospital, the care that you get is exemplary, but there are real warning signs of pressure in the system that we are incredibly concerned about.

**Jim Fairlie:** The last point that I would make is that we are not quite out of the pandemic yet, either.

**Lawrence Cowan:** Absolutely.

**The Convener:** Thank you, Mr Fairlie.

I thank the witnesses for their evidence and for giving us their time this morning. If you would like to raise any further evidence with the committee, you can do so in writing. The clerks will be happy to liaise with you on how to do that.

I suspend the meeting to allow for a changeover of witnesses.

10:39

*Meeting suspended.*

10:43

*On resuming—*

## **Coronavirus (Recovery and Reform) (Scotland) Bill: Stage 1**

**The Convener:** Under agenda item 2, the committee will continue to take evidence at stage 1 of the Coronavirus (Recovery and Reform) (Scotland) Bill. The focus of this evidence session will be on the named person nomination provision contained in part 3 of the bill.

I welcome to the committee Dr Arun Chopra, the medical director of the Mental Welfare Commission for Scotland, and Dr Roger Smyth, chair of the legislative oversight forum of the Royal College of Psychiatrists in Scotland. I thank them for giving us their time and for their written submissions.

I will give members the opportunity to ask the witnesses questions. If one of the witnesses would like to respond to an issue that is being discussed, they should type R in the chat box and we will try to bring them in.

As our witnesses join us remotely, I ask them to introduce themselves.

**Dr Chopra (Mental Welfare Commission for Scotland):** Good morning, convener and members. I am the medical director of the Mental Welfare Commission for Scotland.

**Dr Roger Smyth (Royal College of Psychiatrists in Scotland):** I am a consultant psychiatrist and the chair of the legislative oversight forum for the Royal College of Psychiatrists in Scotland.

**The Convener:** What are the potential benefits and risks associated with the proposal to remove the requirement for a nominee as a named person to have their signature witnessed by a prescribed person?

10:45

**Dr Chopra:** There are many benefits to the proposal that we remove the requirement that the named person's signature is to be witnessed. If I could lead with some data on it, that would be helpful to the committee.

There are various provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 to ensure that, when a person is detained under the act, their rights are protected and their voice is heard, especially at times when they are quite vulnerable. One of those safeguards is the ability for a person to nominate a named person. One of the processes involved is that the named person's signature is required to be witnessed.

At the Mental Welfare Commission, we have a duty to monitor how the 2003 act is working. From some of the data that we hold, we have found that the uptake of the named person provision is around 25 per cent. That is, around 25 per cent of the people who are detained under the act have a named person.

From looking at three years' worth of data, including last year's, we have found that, despite the effects of the pandemic and the need for social distancing, removing the requirement that the named person's signature be witnessed did not lead to a reduction in the number of people who have that safeguard. Therefore, the proposal has a real benefit in reducing bureaucracy and allowing people to exercise their rights through having a named person.

**Dr Smyth:** I agree with Dr Chopra. The benefits of the proposal relate back to the benefits that the framers of the 2003 act saw in having a named person at all. The Mental Health (Care and Treatment) (Scotland) Act 2003 introduced the idea of a named person so that, instead of simply going to the next of kin, an individual who was or might be subjected to the act's provisions could identify a named person to look after their interests, represent them, help them to exercise their rights and be kept informed about procedures under the act.

Given the benefits that the framers of the act saw in that and that we as psychiatrists would like to obtain for our patients, we want to expand as far as possible the ability of people to have a named person when they are treated under the act. The proposal in the bill, although it is comparatively minor, will enable that to happen.

**The Convener:** What are some of the issues that are encountered when organising the witnessing of a named person nomination? Does any of them predate the pandemic?

**Dr Smyth:** The procedure for identifying a named person was changed somewhat with the amendments that the Mental Health (Scotland) Act 2015 made. Prior to that, if no named person was identified, a default named person was identified. That provision was removed except for in relation to individuals under the age of 16. Alongside it was the proposal that there be a signature by the nominated person and that that signature would be witnessed by an individual from a set list of professions.

The reason why the proposal is to be enacted through the bill when many of the other easements in the coronavirus legislation are not is because it is easy to foresee that, at a time when it is not possible to bring together multiple professional groups and fewer professional groups are available on site in the sorts of places where

patients might be looking for them, the requirement for the signature to be witnessed might provide an additional hurdle. However, that hurdle always existed. In general, the greater the complexity of any procedure, the less likely it is to be carried out accurately and completely.

The amendments in the 2015 act were made to try to reset the balance. There is a balance to be struck here between, on the one hand, upholding the rights of individuals to have a named person of their choice and for as many people who want a named person to be able to identify and notarise them and, on the other, ensuring that people are not placed in the position of becoming a named person unwillingly, unknowingly or without proper scrutiny of the roles that they would be expected to undertake.

The 2015 act moved the balance a little bit more in favour of protecting those who might be unwillingly nominated, and this small tweak to the procedure will make things slightly simpler and more straightforward and move the balance back to making it fractionally easier for an individual to obtain a correctly nominated named person. Having experienced its use through the pandemic, we saw real if small benefits from it and did not identify any attendant risks.

**The Convener:** Thank you for that helpful historical insight. Perhaps I can bring in Dr Chopra.

**Dr Chopra:** I agree with what has just been said, but I also point out that the pandemic has brought in difficulties with the requirement for physical distancing. That made it difficult for named persons to visit people in hospital in order to, for example, witness a document being signed or, indeed, for people to witness the named person signing it.

However, as I have mentioned, it is quite clear from the data that, even before the pandemic, there was not the uptake that one might have expected for a safeguard of such importance. That relates, I think, to knowledge of the safeguard and the need to ensure that people are aware of its existence and to reduce any barriers that there might be as a result of the pandemic—and which there might have been beforehand—to the uptake by individuals of the named person provision.

**The Convener:** Thank you.

**Murdo Fraser:** Good morning. It is fair to say that concerns have been raised with us about the proposed change. The Scottish Association of Social Work, for example, has said that witnessing the signature of a named person provides an opportunity

“to verify the named person ... inform them of the role, allow them to ask any questions, ensure they”

understand

“the responsibilities and to confirm that they are competent and able to perform the functions correctly. This is particularly important since there is little guidance around the role and responsibilities of a named person.”

What is your response to those comments? Do you have any concerns that removing such a requirement will mean that people taking on the responsibility of being a named person will not be fully advised of what the role involves? Perhaps Dr Chopra can respond first.

**Dr Chopra:** I understand the concerns that have been raised about whether the witnessing of the signature actually provides a mechanism for people to discuss with a named person whether they understand their role. The SASW actually makes a crucial and important point in that respect.

However, I am not sure whether we need this additional bureaucratic hurdle of witnessing the signature. We can separate the two things. We can ensure that named persons are fully informed of their rights, duties and responsibilities, as happens in many health boards and local authorities. The multidisciplinary team, the mental health officer and others will discuss the matter with the named person and ask whether they understand what is involved. That can still take place; indeed, there is guidance in that regard that I can talk about in a second.

There is no legislative requirement for the witness to certify that the named person understands their roles and duties—they are just witnesses from that class of prescribed persons. I fully understand the benefits of what the SASW has suggested, but we do not need an additional bureaucratic hurdle. We just need to ensure that that process happens anyway.

As for guidance, there is good Scottish Government guidance called “The New Mental Health Act: A Guide to Named Persons” that the Mental Welfare Commission for Scotland assisted with. I know from speaking to colleagues that, in some areas, that guidance is sent out to all named persons. It is up to date with all changes up to October 2018 so, depending on the outcomes of proceedings, there will need to be some tweaks to it, but the guidance is good and it explains the process well.

**Murdo Fraser:** Dr Chopra, before I bring in Dr Smyth, perhaps I could ask a brief follow-up question. Should a named person nominee be required to declare that they understand their role, rights and responsibilities?



**Dr Chopra:** That is a helpful suggestion. The current form talks about how a person is applying to become a named person. Adding something to that to say that they understand their role or that the role has been explained to them might be a helpful addition that brings in some of the points that the Scottish Association of Social Work made and acts as an additional check for the named person to say that they need a bit more information or that they have read the guidance. That is a good idea.

**Murdo Fraser:** I put the same question to Dr Smyth.

**Dr Smyth:** I agree with Dr Chopra, and especially his final point. I understand the points that the Scottish Association of Social Work made. Its particular concerns certainly should be addressed during the process of identifying and correctly nominating a named person. The issue is whether the procedure of witnessing by a member of a certain prescribed class actually did that. It is certainly not a legislative requirement that they do so and, although we cannot speak to every incident of witnessing, our experience was that that was not the case; they were simply witnessing that the correct person had signed rather than identifying any particular understanding of theirs. The idea that the form should include a declaration as well as information is quite a good one.

The involvement of the named person is a process rather than an event. There are opportunities to engage with multiple people along the way—particularly at the outset, with the mental health professional and with the mental health officer or specially trained social worker who will be involved at the instigation of pretty much every period of detention under the legislation. They will provide a lot of information about not just about the abstract role, but the actual duties that fall upon the named person and the opportunity that they will have to speak when the person for whom they are named person is under any particular section.

It must be a process rather than an event because, if the legislation works as it should, someone would nominate a named person when they were well, and when the prospect of future illness and future treatment under the legislation were at least theoretical and in the future. It is only when those events happen that the reality would be brought to bear. It would be inappropriate to consider that the information that the named person received about their role and responsibilities, and particularly their rights, should be contained within the time of meeting the witness that occurred perhaps a year or more in the past.

There has to be a process of on-going information to the patient about their rights and to

the named person about their rights and responsibilities. We see it as an on-going process that is provided for by multiple other points of contact with the health and social care system rather than something that is contained within a one-off meeting to witness a signature.

**Alex Rowley:** It has been suggested that someone could accept the nomination to be a named person without properly understanding the roles and responsibilities that go along with it. Is that a genuine concern? Have there been problems in the past, or do you think that we are just looking to cut out some bureaucracy and that the measure is no real threat?

I will start with Roger Smyth.

11:00

**Dr Smyth:** I agree with your point. The measure is a small bureaucratic step that did not contain, as we had experienced or could foresee, any real threats to named persons being unwittingly or unwillingly nominated. It is a balance between ensuring that as many patients as possible have a named person of their choice and ensuring that there are procedures so that people do not end up as named persons against their will.

We saw the benefits of expanding the number of people with an appropriate named person because the reduction of unnecessary bureaucracy significantly outweighs the theoretical risk that we as clinicians had not seen in the practice of the 2015 act since 2017 when the new procedures came into place.

Furthermore, an individual has the opportunity to make a declaration that they no longer want to be a named person. Being a named person does not tie anyone into anything. A person's ability to make such a declaration applies throughout their role as a named person. If their personal life has moved on, the duties became more onerous or someone else became more appropriate to take on the role, they could easily make a declaration that they no longer wish to be a named person. They are in no sense trapped. Essentially, we saw the measure as obtaining a benefit at only theoretical cost and no practical cost.

**Dr Chopra:** I recognise your point. Being a named person is a really important role. You have the right to be consulted on any compulsory measures that the person who you are the named person for might be subject to. You have the right to make an appeal on their behalf. Everything that goes from the Mental Health Tribunal for Scotland to the patient would also go to their named person.

The named person role is an important one, which acts as an important safeguard, and you would want anyone who undertakes the role to

understand it very well. There are processes in the law—they have not changed—that ensure that, when someone nominates a person to be a named person, they fully understand who they are nominating and why, and that they are not doing so under duress.

I will move slightly upstream from the named person process. As I said, there is a process to ensure that the person who is nominating a named person is not doing so under any duress and fully understands all the information that will go to the named person.

On data, I have already mentioned that, over the three-year period, only around 25 per cent of people who were detained had a named person. When you break that down by year—2018, 2019 and 2020—there are not huge differences. Even when the measures were commenced in 2020, we did not see a massive rise in the number of people who became named persons, nor did we see a fall. It is important to note that there has not been a huge change as a result of the measure being brought in.

Safeguards are available if someone becomes a named person but is deemed inappropriate to hold that role. Dr Smyth mentioned the mechanisms that are available to the patient at that point to say that they do not want that person to be their named person. There are also mechanisms available to the mental health officer, professionals who are working with the person or anyone who has a role in the welfare of the person to say to the tribunal that that person is not appropriate to be a named person. There are safeguards upstream and downstream of the aspect that Alex Rowley asked about.

**Jim Fairlie:** Dr Chopra, you may just have answered my question. Can you define who would require a named person?

**Dr Chopra:** Yes. The legislation says that any person can nominate someone to be a named person. However, the value of having a named person finds its expression when someone is subject to compulsory powers under the 2003 act.

If a person is well and has a mental health condition that they recognise might cause them to require compulsory treatment in hospital under detention, they can nominate someone to be their named person. They can even do that at the point of detention if they have the capacity to understand what it means to have a named person. That person—I started to talk about this in response to a previous question—will then have all the same rights that the patient has in respect of having all the information provided to them about what is being said about the patient. All the tribunal paperwork will go to them. If a doctor or social worker is planning to take any compulsory

measures under the 2003 act, they have to advise the named person of what they are doing and consult them.

Those are the sort of powers that are involved, and they are the sort of people for whom having a named person is really important. We are talking about some of the most vulnerable people who are subject to mental health law and who get the most benefit from having a named person.

**Jim Fairlie:** I want you to clarify something. That is not the same as somebody being given power of attorney.

**Dr Chopra:** No.

**Jim Fairlie:** It is a separate thing.

**Dr Chopra:** It is a completely separate thing under the Mental Health (Care and Treatment) (Scotland) Act 2003. A safeguard is provided for anyone who has been detained under the act to have someone who is important to them to act as a named person. Dr Smyth emphasised the point about choice. We are talking about someone whom a person has chosen so that, if they are detained under the legislation, the named person will know everything that is going to happen to the person who is detained and will receive all the paperwork about them. The detained person will want the doctors to consult the named person about measures that they are taking, and the detained person will want the named person to be advised of anything that is being done to them. That is what the named person is. That is different from a person who has power of attorney.

**Jim Fairlie:** Excellent. That is of great importance. Thank you very much.

A person is entitled to change a named person at any given time, but, if they are having an episode in hospital for instance, the named person would stay until the episode has passed. Is that correct? I think that you have just answered that.

**Dr Chopra:** Yes—unless the person felt, and they had the capacity to say, that they no longer wanted that person to be their named person. They could make a revocation, and then an assessment would be made on whether they had the capacity to make that decision.

However, generally speaking, people who have experienced an episode of detention will make their nomination for a named person when they are well. They will do that before they are detained again, should that event ever happen—we hope that it will not. They are able to say that they would like somebody to be their named person if that happened.

At the point of an assessment of whether someone needs to be detained, the mental health officer, who will be a specially trained social

worker with extra experience in mental health, will do their utmost to ascertain whether that person has a named person and involve them in any discussion.

I will not go into too much detail, but it is really helpful to understand the pathway. This fits with what Dr Smyth said about not viewing the involvement of the named person as an event but as a process. We have found that, when people are first detained under a short-term detention certificate for up to 28 days under the 2003 act, only 11 per cent of them have a named person. The figure for those subject to compulsory treatment orders who have a named person reaches around 25 per cent. It can be seen that, even during the process of being detained, people are able to take up the safeguard. In saying that, I am conscious that the levels are really low, but it can be seen that, even during an episode of detention, that safeguard becomes available to people.

**Jim Fairlie:** Okay. Will you clarify another issue for me? The bill deals with the requirement for the signature to be witnessed. However, would it make more sense for the legislation to require that anyone who is going to be a named person be given sight of what it means to be a named person and then to acknowledge that? I think that Murdo Fraser made that suggestion.

**Dr Chopra:** I totally agree with that point. It is really helpful for them to have had guidance and to be able to say, "Do you know what? I've been made aware of what powers, duties and responsibilities I have." That would be much more helpful than a bureaucratic step that requires them to find someone who can witness their signature.

**John Mason:** I have one question. You have touched on there being issues other than the one about the witnessing of signatures. There might be reforms to mental health legislation at some stage, so would it be better to leave this one small change until we look at wider issues for mental health legislation? I am concerned that only 25 per cent of people have a named person. Do you agree that there are bigger issues than just the one about witnesses?

**Dr Chopra:** I agree. That is one of the points that was made during consideration of the Mental Health (Scotland) Bill, which is when the 2003 act was last looked at. There was discussion then about the need to promote named persons as a safeguard.

It was in response to this committee that we started to explore the existing dataset to understand the level of uptake of named persons. It would be good to provide a benchmark for Scotland as to the current position, so it is helpful

that we are looking at the issue. We need to do more.

The colleagues to whom I spoke in preparation for the meeting said that we cannot just leave it to the named person. Today, I have talked about mental health officers and their specific duties, but it is the duty of the whole multidisciplinary team to act, and we are talking about a process rather than an event. We all need to do better at ensuring that people or patients who are likely to be detained have a named person.

Should we leave it for new mental health legislation? It is something that we have highlighted now, the pandemic has put a spotlight on it and we have made a change that has been good, so I think that we should press ahead and enshrine the provision so that we can build on where we are. We are some years away from a new mental health act or new mental health provisions in other legislation, and the Mental Welfare Commission for Scotland is there to protect folks' rights, so I am keen that this takes place as soon as possible.

**John Mason:** That is very helpful. Dr Smyth, do you have anything to add?

**Dr Smyth:** I agree with Dr Chopra. John Scott's review of mental health law in Scotland is due to release its second phase of consultation in a couple of weeks, but legislative change is some years away. It is very unlikely that, had there not been a pandemic, we would be asking the Scottish Government to produce primary legislation on the point that we are discussing. Looking at how the legislation that contained the provision operated during the pandemic, we feel that it offered benefits to patients that should be sustained through the several years that lie ahead before new mental health legislation gets on to the statute books.

**The Convener:** That concludes our evidence session. I thank Dr Chopra and Dr Smyth for their evidence and time. If witnesses would like to provide any further evidence to the committee, they can do so in writing. The clerks are happy to liaise with them on how to do that.

The committee's next meeting will be 17 March, when we will take evidence from the Cabinet Secretary for Health and Social Care on the inquiry into excess deaths in Scotland since the start of the pandemic. We will also take evidence from the Deputy First Minister and Cabinet Secretary for Covid Recovery on the latest ministerial statement on Covid-19 and subordinate legislation.

11:13

*Meeting continued in private until 11:22.*

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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