OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Thursday 7 May 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
10th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeane Freeman (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Thursday 7 May 2020

[The Convener opened the meeting at 09:30]

Covid-19 Scrutiny

The Convener (Lewis Macdonald): Good morning and welcome to the 10th meeting in 2020 of the Health and Sport Committee. I thank committee members and the Cabinet Secretary for Health and Sport and her accompanying officials for their attendance in these very unusual circumstances. The committee recognises the very challenging times in which we are living, and we pay tribute to all health sector organisations for their continued dedicated service and hard work at this time.

I ask members to ensure that their mobile phones are on silent.

The first item on our agenda is an evidence session on the provision of personal protective equipment during the Covid-19 outbreak. I welcome to the committee Jeane Freeman, Cabinet Secretary for Health and Sport, who is accompanied by Paul Cackette, director of the Scottish Government's PPE unit, and Mike Healy, interim deputy director of health resilience. Thank you for joining us.

In a moment, I will invite the cabinet secretary to make a short opening statement of up to five minutes. Unusually, because of the challenges of managing a virtual meeting, I will take questions in a pre-arranged order. Once the cabinet secretary has made her opening remarks, I will ask the first question, after which I will bring in each member in turn and invite the cabinet secretary to respond. Once each member has exhausted their questions, I will bring in the next questioner, and so on, until the session is concluded.

I ask for succinct questions and answers; I also ask those who speak to give broadcasting staff a few moments to operate their microphone before asking a question or providing an answer.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, convener, and good morning, colleagues. I am grateful for the invitation to attend the committee to speak about such an important issue.

The safety of our essential front-line workforce is an absolute priority for all of us. We are continuously looking to improve supply and distribution of the protective equipment that is so vital in the fight against the Covid-19 virus.

Since March, we have delivered more than 160 million items of PPE: 117 million items to the acute sector, 35.1 million to social care and 8.1 million to community care. Our job is to ensure that everyone who needs PPE gets the right PPE, at the right time and in the right circumstances. What constitutes the right PPE is, of course, defined by clinical guidance that is relevant to the scenario in which an individual works.

Protecting the people who work in hospitals and care homes and as unpaid carers, along with those who work in other sectors that we support, is a priority. However, it is important to recognise that, at the outset, our normal way of operation in the health service in Scotland was to supply PPE to the health service, with other employers being responsible for their own workforce. That has now changed, as supply chains in social care and to local authorities have in some respects failed, and we have stepped in to ensure that supplies are nonetheless maintained, for the staff, the patients and the residents involved.

There have undoubtedly been challenges, not least during a global pandemic in a globally competitive market. Demand for PPE has been high, and the volume of supply can be unpredictable when compared with the volume that was ordered.

In responding to a constantly changing environment, we are looking at the immediate imperatives of ensuring the safety of our workforce, responding to demand as it changes and, at the same time, planning for future requirements as the demand and—in particular—the supply chains change. We have had to change and reshape our work to co-ordinate the response across the range of sectors that I mentioned. We have established improved essential co-ordination for our PPE response, as we improve our understanding of the demand for PPE outwith health boards, in community settings. As I have said, we have to step in to make up for the failure of private and local authority supply chains, when those occur.

I place on record my thanks to my senior officials, to NHS National Services Scotland and to health boards for their close work together to manage the supply of PPE to front-line workers.

Expanding the work of NSS to support the provision of PPE in social care settings has included supplying personal protective equipment to personal assistants and unpaid carers. I am pleased to tell the committee that, since the weekend, more than 66,000 items of PPE have been distributed across Scotland to unpaid carers

and personal assistants, and we expect that distribution to continue.

As you will know, the Minister for Trade, Investment and Innovation, Ivan McKee, has taken forward a range of initiatives to secure increasingly reliable PPE supply chains from overseas. He is also accelerating work on strengthening our options for PPE supply from within Scotland.

I receive daily updates from NSS on current stock levels of PPE supplies and the plans to replenish those supplies; on the orders that we have in train and our estimates of the reliability of those orders; and on any mitigating steps that are being taken if there are queries about whether an order will arrive when it is due or whether it will be of the volume that was originally ordered. That contingency planning also counteracts the risk of breaks in supply chains or of delays that are outwith our control.

I also want to mention the offers of PPE that we receive from businesses. Those offers are immensely welcome, and they can complement our existing supplier network and our supply chain—we have examples of where that has been the case. Such offers, which often come through less conventional channels, are treated seriously, but they need to be addressed and assessed carefully. We must be satisfied about the quality of the product that is being offered and think about how we can focus on areas of greatest need. As some offers are not legitimate, they must first be checked to ensure that there is no risk of fraud and that they represent value for money.

I know that some committee members have raised concerns about the speed and efficiency of the PPE correspondence mailbox that we established at the start of last month. I have made it clear that any workers in the health care sector who have concerns about PPE should approach the Scottish Government, and many workers have taken up that offer, as have members of the Scottish Parliament.

There was a backlog of requests, many of which did not relate to health, social care or PPE. My officials have been working hard to address that backlog, and I am happy to report that it has been cleared. We are now able to work within the seven-day turnaround period for responding to emails; seven days is the maximum time for a response. Requests are triaged and more urgent ones—for example, from somebody who is on the front line and who does not believe that they have the PPE that they need—are acted on much more quickly. Another new feature of our PPE work is that we now have a single point of contact in each health board.

I hope that that is sufficient to get the discussion going. I know that members will have many questions, and I look forward to answering them.

The Convener: Thank you, cabinet secretary—that was certainly helpful. You mentioned that there were failures in the PPE supply chain at an early stage in the process and that you have taken steps to address those. Currently, where are the greatest pressures on PPE supplies? Where are difficulties arising? What can you do to address those difficulties?

Jeane Freeman: The supply chain failures that I referred to were failures in the supply chain for local authorities for social care and those that continue to exist in the supply chain for care homes. That is why our standard NHS PPE operation, which is run by NHS National Services Scotland, was significantly expanded. That has enabled us to take over where that has been necessary and to ensure that the care at home and care homes sectors could be supplied.

I know that members are very familiar with what we did. In that area, as well as beginning to remodel our supply assessment so that we could ensure that we had the right volume of orders—Mr McKee's support on that was very welcome—we introduced the new distribution routes to health boards, for the hospital setting; for community care, which includes pharmacy; and for social care, through the hubs that have been established by local authorities and the health and social care partnerships. When required, that is supplemented with direct delivery to individual care homes.

Supply pressures change over time. The supply of aprons is probably consistent, and the pressures that we had with regard to the FFP3 masks have been resolved and removed. On the FFP2 mask and the IIR mask—the fluid-resistant mask, which is the one that is most commonly used in most settings—we are confident about supplies. A pressure that arose on long-sleeved gowns, particularly those that are used in non-sterile settings rather than theatre operations, which are most commonly used in intensive care and high dependency units, has also been resolved.

I have said many times that the process is entirely iterative, which is why I see on a daily basis the supply levels that are held by boards and in our NSS distribution centres. We check constantly; I check at least once a day, but colleagues who are involved in this area check almost hourly what the supply lines look like and what mitigating measures we need to stand up or stand down.

The Convener: Last week, you estimated that we would need something in the order of 83 million masks, 108 million aprons and 111 million

sets of gloves over the next 12 weeks. Broadly speaking, are you still working to those ballpark figures? Are you confident that you will be able to maintain that level of supply over the 12 weeks?

Jeane Freeman: Those are broadly the right numbers. An issue for us in modelling demand is that although that is relatively straightforward for us to do for the hospital setting, because we can easily get figures from each board on what they currently hold and match that against what we have in the stockpile, it is more difficult to get the volume of stock that is held in the 1,083 care homes and for social care. The demand modelling is constantly evolving as we feed in the data about what is held as stock in individual settings and what we know that we have in our national stockpile.

Overall, we have taken the precautionary approach, on the basis that we will always need PPE, so if we order more than we eventually need for the current situation, it will not go to waste—we will continue to need it. Of course, that produces a financial pressure that we have to manage, but I think that the precautionary approach is the right one to take.

Looking at the figures for today, taking into account orders in hand that we are confident about, the stock levels in individual boards that we know about and what we have in our national distribution centres, we appear to have stock of the IIR mask that will take us through to November this year at the latest, and stock of hand sanitiser that will take us to July. Of course, the committee will know that, through the efforts of Mr McKee and his colleagues, we now have a production and supply chain for hand sanitiser that is entirely internal to Scotland.

09:45

Emma Harper (South Scotland) (SNP): I have a couple of questions on exercise Cygnus, which took place in 2016. I am aware that exercises and drills in resilience testing and emergency planning are absolutely usual across our healthcare system. Exercise Cygnus was a United Kingdom Government simulation of an H2N2 influenza pandemic. Was Scotland part of that exercise and, if so, what did we learn from it and how can we implement its findings?

Jeane Freeman: Exercise Cygnus was entirely focused on the situation in England. Scotland had exercise Silver Swan in 2015, which pre-dated Cygnus but was also focused on a pandemic flu situation. At that time, flu was globally considered as the most likely infection to create a pandemic. All the planning and recommendations that came from the exercise were predicated on a flu pandemic. The results and conclusions of exercise Silver Swan were passed to resilience partnerships and health boards to inform their individual planning. The principal conclusion for the NHS in Scotland was on the need to create a pandemic stockpile, which we did. A UK pandemic stockpile was also created for use across the four nations.

Our stockpile was created to hold in case of a pandemic. It was of value to us when we began to deal with the coronavirus pandemic, but it was not sufficient in some respects—particularly around the emerging clinical and scientific understanding of how Covid-19 spreads and of its level of infectiousness—and we had to scale up our stockpiling and ordering of particular items of PPE. The exercise was of value in giving us the opportunity to create a stockpile of PPE items, which was untouched and to be used in the event of a pandemic if we needed it, which, as it turned out, we did.

Emma Harper: The recommendations that are implemented by every health board need to be tailored to each, because a difference exists across Scotland between rural and urban areas—for instance, some areas have different numbers of intensive care beds. I presume that it is necessary to allow the health boards to implement recommendations on the basis of the services that they provide.

Jeane Freeman: That is true. In the member's area of Dumfries and Galloway, there is one acute setting, whereas many more exist in the central belt, with intensive care units and so on. Our scientific and clinical advisers' understanding of the nature of the coronavirus infection emerged earlier this year and, as our knowledge increased—informed by what was happening in China, Italy and iteratively as the virus spread—we understood the need for a significant increase in intensive care provision. That had a consequence for the particular items of PPE that were required—the member will know about that much better than I do—and led us into all the additional work on ventilator supply.

The Convener: Will you provide the committee with a copy of the report on exercise Silver Swan for our future reference?

Jeane Freeman: I believe that that is possible; I see no reason why not. At the very least, I can let the committee see the recommendations from the exercise. However, bear in mind that the exercise took place in 2015 and was about a pandemic flu.

The Convener: That is helpful. My understanding is that one of the conclusions of the report was that there was an issue around the fit testing of masks. Were you able to address that issue this year as a result, or was it still difficult to meet the requirements?

Jeane Freeman: The supply of FFP3 masks was challenging. We did not run out of them, but it was challenging at one point. That is no longer the case, because the supply chain is now much more secure.

We also invested in machines that provide an objective assessment of whether masks fit properly. FFP3 masks are exceptionally uncomfortable to wear. They produce skin irritation and indentations on the face because they fit so snugly, as they have to do. We invested in those machines to ensure that individual staff members have confidence that their masks fit properly. Every board area has one—I think that we have 18, which includes one in NSS that is ready to replace any that might fail. The machines provide objective evidence as to whether the mask fits, which provides additional assurance. We invested in those machines because we recognised the concerns and the need for people to be confident that masks fit. The masks are used in the most serious situations in which aerosol-generating procedures are taking place and there is close engagement, so staff members are most at risk of the virus entering their body. The machines are critical to ensure that staff have confidence that their masks fit.

Another point is that the masks are, by and large, designed to fit the male face. I cannot think of another way to put that. Overall, men have different face shapes and sizes compared to the majority of women. At the moment, there is nothing that we can do about that, but we will log the problem to see whether it can be addressed through the design, manufacture and supply of masks so that fewer mitigating measures have to be taken for women when masks do not fit properly. In some instances, that happens because the masks were not designed to fit the shape of the female face.

Brian Whittle (South Scotland) (Con): My question is about the development of the emergency stockpile. I know that the UK Government is advised by the new and emerging respiratory virus threats advisory group—known as NERVTAG—on planning for respiratory disease pandemics, including what stockpiles to hold. What input did the Scottish Government have into the creation of a UK stockpile?

Jeane Freeman: You are absolutely right, and NERVTAG advises us, too. I will correct this if I am wrong, but my memory tells me that Dr Jim McMenamin from Health Protection Scotland is a member of that group, so we have the benefit of his direct engagement, involvement and advice as part of his heavy involvement with our chief medical officer and the group that is chaired by Professor Andrew Morris.

That engagement has informed us on the levels and types of stockpiles for a pandemic flu. We created those following exercise Silver Swan and, since then, we have been carrying out checks based on the NERVTAG advice. Mr Whittle will know that NERVTAG has taken a specific and clear view on the requirement for PPE for defibrillation and deteriorating patient and resuscitation procedures.

Brian Whittle: What is Scotland's representative's position on NERVTAG? Our understanding is that we might have only observer status. If that is the case, why is that?

Jeane Freeman: You are right that Dr McMenamin is an observer on NERVTAG. That is not our choice; NERVTAG decides who it has as members and who will observe. You will also know that, until fairly recently, Scotland was an observer to the scientific advisory group for emergencies, but we are now members of SAGE through Professor Morris. Such decisions are not for the Scottish Government. If they were, we would want to be members of those very important groups, but the groups take those decisions, so we are an observer to NERVTAG.

Brian Whittle: As an aside, I presume that the Scottish Government has pushed to have a higher status in those organisations, but can you confirm that that is the case?

Jeane Freeman: Of course we have. The reason why we are not members is not that we want to be different. Whatever pandemic we are planning for, we have been consistently clear that our objective is to be informed and to be informing through our clinical advisers and scientists. Scotland has many eminent epidemiologists and virologists whom we want to be actively engaged in developing the advice that comes to Government. We want to change situations in which we are observers rather than members, and I am pleased that that has changed in respect of SAGE. It is for NERVTAG to determine whether it will take a different view.

Brian Whittle: Do we have a Scottish equivalent to NERVTAG?

Jeane Freeman: We do not have a direct equivalent, but the advice that feeds into Professor Morris's group comes from NERVTAG and SAGE. The group looks at all that advice and turns things around very quickly. It draws its members from academia and different areas of clinical and scientific expertise in Scotland, depending on what is being looked at. The group then advises us if it thinks that a particular application or element applies to Scotland. For example, it is actively advising us on the advice that comes from SAGE, of which Professor Morris is a member. Our chief medical officer takes part in the four-nations CMO

calls, which often happen daily. The chief nursing officer, the chief scientist and their colleagues are also involved.

All that information comes to us and we get advice from those sources that, by and large, is comparable across the UK, but may differ in some respects during the current pandemic, depending on each country's case numbers and where it is on the curve.

10:00

George Adam (Paisley) (SNP): Good morning from sunny Paisley. The recent BBC "Panorama" documentary talked specifically about the provision of PPE. In particular, the programme highlighted that the European Centre for Disease Control issued guidance on PPE in February, including on the amounts that would be needed, but the UK did not react to that advice by upscaling procurement.

There has been much criticism in the media about the UK Government's procurement process for PPE. Has that had a knock-on effect in Scotland, and did that cause any particular problems for us?

Jeane Freeman: Certainly, we regret that the UK Government did not take part in the first European round of PPE procurement, and we said so at the time. My understanding is that the UK Government is now engaged in that process. We would certainly encourage it to do that.

We have raised a specific issue with the UK Secretary of State for Health and Social Care, Matt Hancock, about a decision that was taken with respect to the Department for International Trade overseas network and the Foreign and Commonwealth Office issuing advice not to support new procurement requests from devolved Administrations. My colleagues in Wales and Northern Ireland and I raised a concern with Mr Hancock about that because PPE procurement is a devolved matter, and any co-operation at UK level is voluntary. The Department for International Trade's overseas networks should be supporting the devolved Administrations, as parts of the UK. We are yet to have a final response to that concern, although Mr Hancock has undertaken to go away and look at that.

Certainly, we look to the Department of International Trade's overseas network to assist us when we are looking to source new overseas supply chains, or when existing supply chains might have glitches. Having that assistance withdrawn will cause us some problems and we need to have that matter resolved. We also need to encourage the UK Government to continue to participate in the European Union-wide procurement exercise.

I want to be clear about that distinction. As I have said many times, Scotland has a network of suppliers, supply chains and a distribution network—which we have obviously expanded considerably—as do Wales, Northern Ireland and England. When we choose to come together at UK level, that is an addition to each nation's approaches, networks and supply chains. At times, that is done to provide additional assurance, and at other times, because it makes sense that, in a globally competitive market, the larger the volume that can be offered, the better the opportunity to secure supply at a reasonable price.

As other members have mentioned, some suppliers are choosing to use the current pressure on supply to increase their prices considerably. That is a regrettable position for them to take, but we have to work with it and take whatever mitigating action that we can.

George Adam: On your point about the issues that the UK Government has had with the procurement of PPE, have there been any HM Treasury consequentials for the Scottish Government from what has happened so far?

Jeane Freeman: No, there have not, yet. From memory, I say that so far we have committed just over £160 million in PPE spend during the pandemic. There is an on-going dispute between the finance secretaries of Wales, Northern Ireland and our own Ms Forbes and the Treasury about consequentials, which we have not yet received. I have raised that twice with Mr Hancock. The health ministers of the four nations have calls every week and, in two consecutive calls, I have said that that needs to be resolved; the consequentials that are due to Scotland must come to Scotland to be set against the volume of spend that we have already committed.

The Convener: The "Panorama" programme suggested that Covid-19 was removed from the list of high-consequence infectious diseases. Was that decision made in Scotland? On whose advice was that decision made?

Jeane Freeman: It was a UK-wide decision to remove it from that category. I will be happy to provide the detail of that later, because I am about to speak from memory and I am neither a scientist nor a clinician, which I am sure you have all noticed by now.

From memory, it was initially placed in that category, but then removed. Although Covid-19 is a highly infectious disease, "high consequence" is about the seriousness of the infection and the number of deaths that arise in the population as a whole. Its removal from the list by scientists and clinicians in no way undermines the seriousness of the number of deaths that there have been so far;

nobody should take it to mean that. However, it is not a high-consequence infectious disease when compared with Ebola, for example. Covid-19 was declassified because it was not considered to be in the same category as a disease such as that.

Those decisions are not made by Governments and politicians; they are made by scientists, primarily, with clinical input. I will ensure that the committee receives a detailed explanation of the timeline for and the factors that were involved in the decision.

The Convener: That would be helpful. The public might be surprised to learn that the scientific advice is that Covid-19 is not considered as a high-consequence infectious disease in the same way as Ebola, so I look forward to seeing those figures. On whose advice was that decision taken?

Jeane Freeman: From memory, the advice came from NERVTAG. Again, I will confirm that for you.

I take your point about how members of the public might hear that. It is about an interpretation of words. You and I would consider any infectious disease that has the potential to cause a high number of deaths—as coronavirus self-evidently does—as of significant consequence.

That is not necessarily how the word "significant" is used in the scientific community, so we will attempt to clarify all of that so that there is no room for misinterpretation or misunderstanding about the decision that was reached in that regard.

The Convener: That will be very helpful. We now move on to Alex Cole-Hamilton.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, cabinet secretary. I have a brief follow-up supplementary on an answer that you have given in response to questions, and I thank you for everything that you have told us.

On the face-fit issue for female healthcare and care workers, you rightly said that the current mask is largely designed to fit a male face, with all that that entails. It might just have been a turn of phrase, but you said that you would seek to have it modified. I think that this issue was first raised a couple of weeks ago—I certainly raised it with you. Given the volume of procurement and the number of players in the field, have you already asked them to do that? Is a prototype being designed, and when will the masks be available?

Jeane Freeman: We have made sure that NSS is aware and that it is talking to its suppliers. However, suppliers supply what others design. Somebody designs those different kinds of PPE, then they are manufactured and we deal with the suppliers to ensure that we get the supplies that we need.

The issue has been raised. I am conscious that we do not want to break the manufacturing and supply chain because we need a different design. Although the current design is primarily for the male face and not the female face, which some women staff members have raised, mitigation is possible, so that women remain as safe wearing the mask as any colleague.

Mr McKee's group looks at manufacturing and design as well as supply, and I know that they will want to take the issue forward with colleagues in Scottish Enterprise and elsewhere. In due course, I am sure that he will want to give you an update on where it has got to, or I can do so.

Alex Cole-Hamilton: Thank you. My substantive question is around an issue that we encountered earlier in the emergency, when we identified that some of the PPE that was being supplied to the front line was out of date. In some cases, the use-by date had been covered up with a new use-by date or doctored. Can you take us through that issue? I am not suggesting that anything nefarious was going on, but did we always give safe PPE to staff who were on the front line?

Jeane Freeman: The answer is an unequivocal yes. We always gave safe PPE to staff who were on the front line. For example, a mask with a particular design, or product number 1863, was found when it was issued in the Scottish Ambulance Service to have a ratio of about 34 not fitting to 36 fitting. As soon as that point was hit, the mask was withdrawn and new masks from a different stockpile were issued. We are very focused on ensuring that the PPE that we issue is safe. Unison raised directly with me the other example of gowns that were issued in Fife. Although the front provided adequate cover, the back did not, so they were removed and new gowns issued.

We take very seriously indeed the supply of PPE and its quality and adequacy, so I gently take issue with your use of the word "doctored". The masks that were issued were not doctored. They were rechecked by the manufacturer and cleared by the Health and Safety Executive as safe for use. The masks were in the original pandemic stock; before we drew them out, we asked the manufacturers to recheck them to see whether they could be used and then asked the Health and Safety Executive to do its work to reassure us that they were safe. If the Health and Safety Executive had come back and said that there was a question around them at all, we would not have used them. That is the basis on which they were then issued.

10:15

Alex Cole-Hamilton: Forgive me—my choice of words was perhaps unfortunate. By "doctored", I meant that the original use-by date was covered up by a new one, but the cabinet secretary has covered why that was, for which I am grateful.

I have a supplementary question to that before I come on to my final question. My brother-in-law, who is a physicist in North America, has designed a machine that can decontaminate PPE for reuse using ultraviolet light. Are we considering that here? Is there a means by which we can safely reuse PPE if it has been decontaminated?

Jeane Freeman: Work is currently being led by NSS on whether non-sterile gowns can be laundered for reuse, including on what the material would need to be, what temperature the laundering would need to be run at, and the safety check. That work is under way to see whether that particular area of PPE could be supplied by reusable gowns, but it would not be possible for other items such as, for example, aprons or gloves. Work is also under way on reusable visors, but again it depends on the material from which they are made and the means by which they are cleaned and reused.

I am not clear about gowns, but if I was issued with a reusable visor, I would keep it. I would not pass it to you; instead, I would keep it, clean it, and use it again. It could be reused for a set amount of time or—if you like—number of occasions, but it would not be transferred to another member of staff. I am not clear about the situation in relation to the relaundering of gowns. However, work is under way in both of those areas to consider whether that can be done safely.

Alex Cole-Hamilton: I have a quick final question, which is slightly wide of the medical use of PPE and is about PPE in the community. There is still a lot of confusion about face coverings in shops. I have had correspondence from shopkeepers in my constituency asking whether they should be insisting that people who come into their shops wear face coverings.

Jeane Freeman: As Mr Cole-Hamilton will recall from what the First Minister said, although the science on the protective value of face coverings—not masks—is weak, it indicates that, on balance, there is a value to wearing them. That is why we issued advice to wear them, but did not make it mandatory or put in place any kind of requirement.

The value of a mask is that, if I was wearing one, it would protect you from me should I have the virus. It would not protect me particularly, but it would protect you from any droplets that might emerge when I am speaking or should I cough or whatever. However, that advice does not substitute for any of the other strong rules about social distancing or the absolute importance of proper hand washing and respiratory hygiene; that is, coughing and sneezing either into your elbow or using a tissue that you then dispose of.

It is advice to members of the public that should be considered by and large in situations where physical distancing is not possible, which could be the case in small shops. My own corner shop, for example, permits only one customer in at a time. It is a small shop. Given its size and the amount of stock that it has, physical distancing in it would be impossible, so it permits one customer in at a time and attempts physical distancing between the cashier and the customer. In addition to that, although our supermarkets are managing very carefully the number of customers that they allow in at one time, you could also see that situation in supermarkets.

Many supermarkets have now marked out a specific route to try to ensure that customers remain physically distant; nonetheless, two customers could both be leaning forward to pick up the same packet of tomatoes. In those circumstances, people may feel more comfortable and assured about wearing face coverings.

With respect to your question about shopkeepers, it really has to be a decision that they take, based on what they feel is the most protective and safe environment for them to be operating in their shop.

The Convener: We now come to Sandra White, who has questions on care homes.

Sandra White (Glasgow Kelvin) (SNP): Good morning, cabinet secretary. First, I record my sincere thanks to everyone who is working on the front line during this terrible pandemic.

I will concentrate on the topic of care providers. In your opening statement, you mentioned the different care providers that we have. We know that 74 per cent of care providers are from the private sector. Could you clarify who should be providing and sourcing PPE for care homes during the pandemic? Normally, care homes would source and provide PPE, but should the Government take responsibility for that during a pandemic?

Jeane Freeman: During a pandemic, it is a shared responsibility. Care homes, whether they are run by the private sector, by the independent sector or by local authorities, have a responsibility as employers to ensure that their staff are provided with a safe working environment. That covers many aspects, including, of course, PPE.

In the normal course of events, care home providers have their own supply chains and suppliers that they have chosen to use. In some

respects, the system has fallen over—the supply chains have failed because of the global demand for PPE and the highly competitive nature of that market. We therefore set up a direct order route so that care home providers and, indeed, home care, can ask for supplies from the NHS NSS stockpile. We then set up a direct distribution route.

In our discussions with providers, our original estimate was that we would supply about 20 per cent of their need. I do not have the up-to-date figures, so I do not know whether that is still the case—my feeling is that we are supplying more than that amount because some of the usual supply lines have fallen over. However, we will continue to supply them with the PPE that they need—we have issued guidance about what PPE care home staff should have—because the overall objective is to ensure that staff in care homes are safe, which enables them to care safely for, and thereby protect, the residents.

There are two key aspects to PPE. The first aspect is not only having it, but knowing how to use it—in particular, how to put it on and how to take it off, so that users remain safe. We need to be sure that staff in care homes, as in our NHS, have the right training to use PPE to its best effect.

The second aspect is that, although PPE is very important, it is no substitute for good infection prevention and control measures. The two go hand in hand. Having adequate PPE in a care home or in any other setting is important, but on its own—without good measures, standards and practices for infection prevention and control—PPE will not be sufficient.

Sandra White: I take on board the fact that NHS supplies are being used for care homes. As I mentioned, 74 per cent of care homes are privately owned. You are right that employers should look after their employees and the people who they are caring for.

You mentioned exercise Silver Swan, which took place in 2015. Were care home or social care providers involved in any of the discussions around exercise Silver Swan? I know that you were not the health secretary at that time, and I will understand if you have to look into that. Were providers involved in any discussions about what to do if a pandemic were to happen? Do you know the answer to that, or can the documentation on Silver Swan tell us that?

Jeane Freeman: I was not an MSP at the time, far less the health secretary. My understanding is that those providers were not part of the exercise. All pandemic exercises—and any other exercises that are conducted to test security and resilience—involve the different levels of government. Local government would have been involved in exercise Silver Swan, but individual private care home providers would not necessarily have been involved.

Local government has a statutory responsibility for the care and protection of vulnerable adults. That covers, to some degree, the care sector and its responsibilities. Local government would have been involved in the exercise, but I do not think that individual care home providers, or that sector, were involved.

Sandra White: My final question is about the supply of and demand for PPE. Would it have been possible to distribute PPE from the centre to all who needed it, rather than leaving that up to individual care home providers?

Jeane Freeman: That is, to a degree, what we are now doing. We are securing the supply of PPE and centrally distributing it to the social care sector, to the primary and community care sector and to the acute setting. Our responsibility—my responsibility—is to the NHS. No one other than Government, and therefore no one other than me, is responsible for supplying PPE to the health service.

The situation for the social care sector is as I have described it, although we are now—rightly—taking a much more direct role, and have done so for a number of weeks. We are ensuring that PPE is supplied to staff and residents, and now we are ensuring that is also supplied to unpaid carers and personal assistants.

This is a changing situation, and we may not keep that arrangement in place as we come out of the pandemic. There may be significant changes in a number of areas as a result of our learning and the practice that we have adopted, not least in how we deliver healthcare. That could be the subject of a very useful discussion. Other changes may come from this pandemic. That is something that we will all discuss and decide on at the appropriate time.

Undoubtedly, we are all learning how to approach those matters as we go, and there are many changes that we will not want to lose because they are genuine improvements in how we deliver a range of health and social care. However, we will get to that point when we get there.

10:30

The Convener: The Scottish Government is procuring and distributing PPE to the social care sector and others outwith the NHS. Are those care homes reimbursing the Government for supply of that PPE?

Jeane Freeman: They are not, at this pointI I am sure that they will when we have a discussion with them about the overall cost. They will be

making savings, because the Government is supplying them with PPE that they would normally be spending money on. However, our primary interest is to ensure that the PPE gets to where it needs to be. We will do the tally up later. We will begin our discussion—through Scottish Care, I expect—about reimbursement of costs.

Miles Briggs (Lothian) (Con): I wish a good morning to the cabinet secretary and her officials. You have outlined that a significant amount of the PPE that Scotland is now using in the NHS and care homes has come from outside the EU—specifically from China. Do those orders meet all the criteria that you have outlined? What inspection regime has been put in place?

Jeane Freeman: In order to join our supply chain, a supplier and, through it, the manufacturer, have to provide us with evidence—currently, that is usually in the form of photographic evidence; in normal times, we might receive samples—of what they intend to supply, where it has been validated and an assurance of the quality.

Provided that we reach agreement on the volume that they can supply and the price that they will charge, we place an order. When that order arrives, the items are checked to ensure that they meet our requirements and are what we were advised they would be like when we placed the order.

All the quality checks happen before an order is placed and once it is received. They happen regardless of where the supply comes from—from overseas or from the supply chains that Ivan McKee, the Minister for Trade, Investment and Innovation, has successfully set up for manufacture and supply of some PPE items in Scotland, which, at the present time, applies to masks and sanitizer in particular.

Miles Briggs: Do you have data on how many unsuitable or rejected pieces of PPE have been received in Scotland, and how much has been spent on that during the pandemic?

Jeane Freeman: I do not have that information with me. I am happy to ask NHS NSS to supply me with it as best it can, and to ensure that the committee members receive it, through the convener.

Miles Briggs: During this period, there has been a need for mutual aid across the UK. Can you outline to the committee what PPE has been moved around the UK, and when that has taken place?

Jeane Freeman: I do not have the full detail of that for all four UK nations. I know that we supplied 1.1 million fluid-resistant masks to Wales about 10 days ago. It will return that when its own order arrives. Colleagues in Wales have supplied gowns to NHS England; I believe that colleagues in Northern Ireland did that, too. A very important level of mutual aid and co-operation is being undertaken.

Mr Hancock and I are in discussion about PPE. He believed that 11 million items of PPE had been supplied to Scotland from the UK stockpile, but our figure is 7.5 or 7.1 million, so more of that is still to come to us. That PPE is from the UK pandemic stockpile; it is not mutual aid.

We are conscious of the levels of stock that all of us hold, so we know in what instances we can approach one another for mutual aid to cover any periods between the rundown of stock and the expected delivery of an order. Indeed, I think that the first or second aircraft that arrived at Prestwick airport—Mr McKee has my gratitude for that—contained masks for NHS Wales. Some of that supply is mutual aid, but there is also sharing among the four nations.

David Stewart (Highlands and Islands) (Lab): I would like to talk about the important area of health and safety at work. What estimate do you have of the number of health and social care workers who have become infected with the virus at work?

Jeane Freeman: We do not have that data. Of course, we know about the level of absence in the health service as a consequence of Covid-19; it is declining and is now running at around 4.2 per cent. However, not everyone who is not at work is absent because they have the infection. Some will be staff who are shielding themselves, as per our advice. Some will be looking after a family member who is shielding. That 4.2 per cent of staff do not all have the virus.

Regrettably, we also know the number of deaths among health and social care staff. However, it is difficult to know whether an individual has acquired the virus at work, because the incubation period of the virus, as you know, is about three weeks. We have asked colleagues at Health Protection Scotland to see whether there is a robust methodology that could be used to identify whether a working environment has been such that an individual has acquired the virus. It would be reasonable to think that that might be the case in some instances, but at this point there is no factual evidence to substantiate it.

David Stewart: How many staff have refused to work because of legitimate fears about PPE?

Jeane Freeman: I am not aware of any members of staff in Scotland who have refused to work because of their concerns about PPE. Considerable concerns were certainly expressed in NHS England, at a point where staff were seriously challenged in the provision of non-sterile gowns. I recall a degree of media coverage of

concerns expressed by the Royal College of Nursing and possibly the British Medical Association—although I am not sure of that.

I speak to the RCN every week. We have discussed PPE, and it is not a concern that the RCN has in Scotland. I also speak to the BMA and Scottish Care every week, and PPE is always a subject of discussion. I will talk to Unison later today or first thing tomorrow, and I am sure that PPE will be part of that discussion too.

My senior officials in human resources and workforce hold a twice-weekly call with what we call the leadership group—which involves all the health and social care unions such as Unison, Unite, GMB, the RCN and the BMA—on a range of issues, as we progress them. Undoubtedly, those issues always include PPE. The last time that I joined the call, one of the Unison representatives raised a concern about the gowns that had been issued in Fife, and we acted on that that very afternoon.

I am not aware of any member of staff in Scotland who has refused to work because of PPE concerns. People have obviously had concerns, but we act on them as quickly as we can once we know about them.

David Stewart: Has the Health and Safety Executive been involved in the provision of PPE in the NHS and in social care?

Jeane Freeman: The most direct involvement that I am aware of was in checking for safety and assurance the masks that we discussed earlier. The HSE did the final check and that was our assurance that those masks were safe to issue and use.

David Stewart: My final question relates to litigation. What assessment have you made of the level of litigation raised at the door of the Scottish Government as a result of staff becoming infected at work, and have you made any budget contingency to provide compensation to the workforce for successful claims because of infection at work?

Jeane Freeman: The contingency question is one for Ms Forbes and I will not answer on her behalf. I am not aware of any litigation claims in that respect at all.

David Torrance (Kirkcaldy) (SNP): A key concern is that there might be a second wave of infection when lockdown measures are lifted. Does the Scottish Government plan to create a stockpile of PPE in anticipation of a second wave, and how likely is a second wave of infection?

Jeane Freeman: We run a continuous stockpile. Our national distribution centre in Lanarkshire holds a volume of items of PPE and a range of items that our health service needs, including medicines. That is our running stockpile. I talked earlier about the length of time for which we have items of PPE either in hand or at board level and mentioned then that we have orders in the pipeline that take us through to the end of the calendar year and in one instance—from memory—into January of next year.

Whether there is a second wave depends in large measure on the degree to which we can continue to successfully suppress the virus by reducing the number of cases, the number of individuals in ICU and the number of deaths. We must then have an active and vigilant test, trace, isolate and support strategy in place and operational at the point at which we lift any of the current restriction measures to any degree.

Viruses go away and die off to the extent that we can prevent their transmission. The current lockdown measures, and all the other steps that we know about and are taking, are in essence about stopping the transmission of the virus. Once we begin to raise any of the lockdown measures, we need to have something else in place to stop transmission. Test, trace and isolate is a central part of that strategy, as well as continued physical distancing, good hand hygiene and so on.

We are constantly balancing all that against all the other steps that we have in place. Test, trace, isolate and support is a key element of that. We will need to keep doing that until we get to a point at which there is a vaccine for the virus. At this stage, it is not clear when that will arrive. It may be in the early part of next year, or later. Clinical trials will be needed; there is no point in having a vaccine if it is not effective.

10:45

A vaccine is our best security against an infectious disease such as Covid-19—we should remember, for example, how effective the measles vaccine is in suppressing that infection among children across the whole country.

Whether there is a second wave of Covid-19, and the height that such a wave might reach, depends on the decisions that we take to ease the measures of the lockdown, and the mitigation steps that are actively in place—and robustly followed—against any risk of an increase in cases that is due to the lifting of a level of the current restrictions.

David Torrance: What has the Scottish Government learned from the infection about the items that are most needed?

Jeane Freeman: That is quite a hard question to answer.

Some of the items that are most needed are aprons, gloves and eye protection. There is a significant demand for fluid-resistant masks.

Demand for FFP3 masks is largely dependent on the numbers of people who are in intensive care. As the two areas most likely to use aerosol-generating procedures, intensive care and the emergency department need those very highly protective face-fitting masks. However, fluid-resistant masks are required across a range of settings in health and social care, as are aprons and gloves. Those items are probably in highest demand by volume, and we have to ensure that we have them in hand—at board level and in orders.

That will all feed into the significant exercise that I am sure will get under way as we move through the pandemic, about our planning for future pandemics—bearing in mind that planning is based on assumptions that do not necessarily play out in a real situation.

The Convener: Thank you very much, cabinet secretary. Two members have brief supplementary questions.

Emma Harper: Thank you, convener, for allowing my supplementary question.

This morning's newspapers have talked about a briefing from the UK Government, saying that it will very soon lift the restrictions that are preventing the spread of Covid-19. Has the Scottish Government been made aware of that briefing, and has the UK Government advised you about those proposals?

Jeane Freeman: In my weekly call with Matt Hancock, Vaughan Gething, who is the Minister for Health and Social Services in Wales, and Robin Swann, who is the Minister for Health in Northern Ireland, we touched on the fact that the current measures would be reviewed today. We three said to Matt Hancock that if we are to continue the four-nations approach—which we want to do—we all need to be actively engaged in developing the approach to easing the current lockdown measures. That includes not only engaging on what the measures might be, using advice from SAGE, but on timing for all of them.

I, as health secretary, have not been engaged in that discussion, and discussion of it did not form part of the conversation with Mr Hancock. He heard what we were saying, but we did not have a discussion about it. The advice from SAGE comes to all four nations; we are all aware of it and our four chief medical officers are involved in it. We want as far as possible to take a four-nations approach to easing the lockdown measures, as we approached the four-nations plan. Members will recall that it was one of the very early publications, and all four nations were actively involved in devising it.

We want to take that four-nations approach, but as the First Minister has said clearly, and as I have said, at the end of the day, my responsibility is for the health of the population in Scotland. I will take a view—which I will feed into my Government's view—that will be based on the evidence that I have about where we are right now in suppressing the virus. We do not think at this point—although the signs are hopeful—that the reproduction number is sufficiently low to give us much room for manoeuvre without risking the progress that has been made, largely as a consequence of what the public of Scotland have done. We cannot risk that progress being very quickly put into reverse. All views will be fed into whatever discussions occur between the four nations, so I hope that we can reach a shared view about what we will do.

The Convener: Thank you. Finally, and briefly, Brian Whittle will ask questions.

Brian Whittle (South Scotland) (Con): I would like to hypothesise a little bit. I think that it is fair to say that emergency stockpiles of PPE and distribution avenues have, at the very least, been put under a great deal of pressure. Given your answers about the Cygnus and Silver Swan exercises, I suggest that this kind of pandemic was not planned for. It was probably known that it would happen at some point, but across the globe it was probably hoped that it would not happen on our watch. Is it fair to say that such a pandemic was not planned for? That is not a criticism of the Scottish Government; we could say exactly the same across the UK and about other Governments. In reality, we were not set up for this, which is why we are under so much pressure.

Jeane Freeman: I think that what it is fair to say is that the pandemic planning that was undertaken across the UK was for a coronavirus; flu is a coronavirus. This particular coronavirus is about 140 days old. All of our knowledge of it, from when it first emerged—what it is like, how infectious it is, how it spreads, the damage that it can do to individuals who contract it, and in particular people in the age groups and with the vulnerabilities for which it is most serious—has been learned over those 140 days.

When pandemic planning is done, of course a number of assumptions must be made. In as much as the virus is a coronavirus, the assumptions that were made for a coronavirus pandemic were reasonable. However, this particular coronavirus affects, in its most serious form, a very particular cohort of people and poses the greatest risk to them.

We are now seeing emerging evidence about the possibility of longer-term damage to individuals

who contract and survive the virus. Evidence on the effects on long-term respiratory health, and in some instances renal health, is causing clinicians some concern. Research is under way on long-term damage to the organs of people who get the virus and survive. We will have to take account of that research when we think not only about when and how we stand up the paused areas of the health service, but about whether there will be new demands on the health service that were not there before the pandemic.

I would not say that there is nothing that we should learn for future pandemic planning. It would be unwise to assert that: of course there are things to learn. However, I would not be critical of the pandemic planning that has gone before, because it made the right assumptions for a coronavirus pandemic, in the knowledge that the particular strain of the coronavirus that would have to be dealt with if the situation became reality could be different in important ways from the coronavirus that was being planned for.

Our knowledge and understanding of Covid-19 has been changing constantly from day 1 to now, and it will continue to change as we learn more about it, as scientists undertake more research and as we continue modelling. One of the best examples of that is the initial view that asymptomatic individuals were not infectious. In a relatively short time, that view changed, which informed a change in our approach to breaking transmission of infection.

The Convener: I am certain that the questions about what lessons are to be learned, and how they fit into wider pandemic planning, are ones to which we will return in a future meeting.

Thank you very much for your participation, cabinet secretary. I also thank your officials for their attendance at what has been the committee's second formal remote meeting. You said that you would provide us with further information on a number of issues.

I apologise to my colleagues who wanted to come back in to ask further questions, but have not been able to do so. I am sure that their thoughts will inform a letter that we will send to the cabinet secretary with questions in addition to those on which she has commented.

That concludes the public part of the meeting. Our next meeting is provisionally scheduled for Tuesday 12 May, which is only a few days away. That will be notified in the usual way in the *Business Bulletin* and on the committee's social media.

10:58

Meeting continued in private until 11:25.

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