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Health and Sport Committee

Wednesday 27 May 2020

Session 5

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Pàrlamaid na h-Alba

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CONTENTS

HEALTH AND SPORT COMMITTEE
13th 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)
Caroline Lamb (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Wednesday 27 May 2020

[The Convener opened the meeting at 10:00]

Covid-19 Scrutiny

The Convener (Lewis Macdonald): Good morning, and welcome to the 13th meeting in 2020 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are in silent mode.

The first item on our agenda is an evidence session on testing for Covid-19, in which we will look at the strategy so far and the way forward. We will focus on testing capacity, types of test and the overall testing strategy. I welcome to the committee Jeane Freeman, the Cabinet Secretary for Health and Sport, who is accompanied by Caroline Lamb, the director of the test and protect portfolio in the Scottish Government. 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 such as this one, we will take questions in a pre-arranged order. Once the cabinet secretary has made her opening remarks, I will start off the questioning before asking each member to ask their questions and inviting the cabinet secretary to respond. We will proceed in that way. I ask everyone to keep questions and answers succinct and to give broadcasting staff a few seconds to operate the microphones before beginning to ask a question or to provide an answer.

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

The Cabinet Secretary for Health and Sport (Jeane Freeman): Good morning. I thank the committee for giving me the opportunity to have a conversation about testing, which is a key element of, and has critical role in, our response to the challenges of Covid-19.

As the committee will know, the symptoms of the virus are the same as those of many other diseases and infections, such as flu, bacterial pneumonia and even the common cold, so testing is important in enabling us to identify who has this specific virus.

For that reason, to date, we have had three priorities for testing: directing our testing capacity effectively to save lives and protect the vulnerable; ensuring that critical staff can return to work as soon as possible if it is safe for them to do so; and monitoring and reporting on the spread and prevalence of the virus. Looking ahead, we will continue to focus on those three priority areas, including testing care home staff and residents with or without Covid-19, as well as children aged five and over, while expanding to do more testing of people in the community so that we can identify cases of Covid-19 and, through test and protect, stop further transmission of the virus.

The tests that we have—polymerase chain reaction, or PCR, tests—have proved to be highly accurate, but, as is the case with many medical tests, they are not 100 per cent accurate. Recent research in Edinburgh found that the tests have a sensitivity of 91 per cent—that is, they will identify 91 per cent of clinical cases of Covid-19—but they have a specificity of 100 per cent, which means that they are accurate in detecting only the virus that causes Covid-19 and not other viruses. That is particularly important, given what I said about the commonality of some of the symptoms of Covid-19 and other infections.

The tests are not perfect and there are limitations in how useful they are for testing people who do not have symptoms. That is because the PCR test detects RNA from the virus but cannot distinguish between active virus, which causes infection, and fragments of virus, which might still be found long after someone has recovered. The test also cannot tell us whether someone is early in incubating the disease but does not yet have high enough levels of virus to be picked up.

Testing advances are continuing apace. They continue to be pursued in terms of how we take the tests, their accuracy and what they tell us about the disease.

Our approach to testing, in common with that taken in countries elsewhere in the United Kingdom and more widely, has developed as our understanding of the virus has improved and as testing capacity has increased. It is worth remembering that we have come a significant distance in a relatively short timeframe.

For Covid-19, we have had to build our testing capacity from scratch, with the first testing available in Scotland from 10 February this year and a capacity of 350 tests per day in two labs. We have now built up to a capacity of 15,500 tests a day, with plans to increase that further over the coming weeks and months to ensure that we have sufficient capacity to meet what we anticipate to be a growing demand.

I know that there are many questions in this area—it is an area of significant importance—so I will stop there. I am happy to take members' questions now.

The Convener: Thank you very much for that, cabinet secretary. I will start.

You have spoken about the priorities at the outset and about the need to ensure that capacity was directed effectively. We understand that. There have been criticisms, however, about how far capacity was mobilised and about whether more could have been done at the outset. The deputy chief medical officer for England, Dr Jenny Harries, told the House of Commons Health and Social Care Committee that, if there had been unlimited capacity, things would have been done differently. My first question is about whether that is true in Scotland, too. If you had had greater capacity, would you have adopted a different strategy at the outset? For instance, would you have stopped the testing and tracing that was done up until 3 April? Would you have taken a different approach had the testing and laboratory capacity been mobilised at the outset?

Jeane Freeman: That question is quite difficult to answer, because the testing capacity was what it was—although it had grown significantly by April. The use of the testing capacity was, in part, demand led in as much as it was there and we used it from the outset to test individuals in intensive care units and respiratory wards. It was focused partly on surveillance but primarily on key workers, and the key worker testing is largely demand led in that key workers come forward.

Remember that, in the early days, there was significant evidence to indicate that there was no value in testing asymptomatic individuals, although the debate around that has moved on. As I tried to indicate in my opening remarks, it is still not definitive that there is value in testing asymptomatic individuals, but that position has moved. We are now testing asymptomatic care home workers in care homes, and we are giving consideration to testing health workers in other settings.

Capacity undoubtedly has an impact, but the capacity grew relatively quickly. The clinical advice that we were receiving was that, at the point at which community transmission was so significant that contact tracing—test and trace—was no longer viable, we had to shift from the containment phase to the delay phase. At that point, what we were using testing for, or who we were pushing it towards, changed.

Even if we had had the capacity for 15,000 tests at the outset, I am not certain that we would have taken a significantly different approach, given everything else that was known and the advice that we were receiving.

The Convener: When you reflect now on the position that we have reached, on the advice of the World Health Organization and on the experience of other countries such as South Korea, where far more laboratories were mobilised at the outset and far more effort was made at the outset to test in the community and to isolate those who might have been infected, do you wonder about the efficacy and correctness of the clinical advice that you received two months ago? Do you wonder whether a different approach might have put you ahead of the game at an earlier stage?

Jeane Freeman: I would not feel qualified to challenge clinical advice—the content of what clinicians tell me. I, along with others in Government, have to make a judgment about what I do with that advice.

Do I now think, on reflection, that if we had had greater capacity in February, or even at the end of that month into the very early days of March, we might have used testing differently? We may have taken a judgment, notwithstanding the clinical advice, that we wanted to widen testing availability to those who had symptoms even though, at that point, we were still engaged in contact tracing. We might have looked at different age groups but, again, the decision to widen testing to cover different age groups came as a consequence of increasing evidence. In the early days, for example, there was debate around testing children. The advice is now clear that it is perfectly possible and correct to offer testing to children who are aged over five; however, the debates have raged back and forth.

It would be wrong for me to say, even with hindsight, that I think that every one of the decisions that we took and all the judgments that I made were absolutely correct—it would be foolish to take that position. However, I am not absolutely certain that, in the circumstances, given what I knew—and even with more testing capacity—I would necessarily have taken a different view at the time.

The Convener: One of the criticisms has been that, at the time of the lockdown, university laboratory scientists and researchers were stood down and sent home instead of being mobilised to add to your testing capacity. Do you think that that was correct at the time? Perhaps more importantly, are all the potential sources of laboratory testing capacity now in place and being used to the full?

Jeane Freeman: We will have reached a testing capacity of 15,000 by the end of the month, in part by mobilising. We now have testing laboratories and testing capacity in every health board across Scotland, and we have mobilised with our academic partners to add to that capacity. We have also brought in the Scottish National Blood Transfusion Service.

However, as I said in my opening statement, we need to go beyond that to cope with all the anticipated demand, including what we estimate might be demanded of us under the test and protect scheme. That will involve further discussions with our academic partners and consideration of whether we can, with them, have a single larger laboratory that can process more tests, as well as some discussion with private providers. Nonetheless, our first port of call will be our academic partners, to see whether they can do more. There are also initial discussions under way with other public agencies such as Marine Scotland about whether their capacity can be used to assist with testing.

The issue is not just the existence of the laboratory—we need the right kit and the right reagents and chemicals, and staff need to know how to do the test. The situation is therefore not straightforward—it is not necessarily overcomplicated, but all those elements need to work so that the test is compatible across all our laboratory sources for testing.

The Convener: I have one final question. A few weeks ago, the report on exercise Silver Swan to prepare for pandemics was published, but it does not appear to cover testing. Was testing not considered as part of that exercise? If so, was that because those pandemic preparations were focused wholly on the possibility of an influenza pandemic?

Jeane Freeman: That is right, convener. Testing was not considered, and my understanding is that that is because the exercise was focused on influenza. That was the case because all the international evidence pointed to the strong likelihood that, if we were to face a pandemic, it would be an influenza pandemic.

10:15

Emma Harper (South Scotland) (SNP): Good morning, cabinet secretary. Yesterday, I lodged a written question about the test, trace, isolate and support strategy that the Scottish Government is introducing. In your response, you said that it would go live on Thursday 28 May, following successful pilots in NHS Fife, NHS Highland and NHS Lanarkshire. Can you give me an additional update on progress towards implementing the strategy?

Jeane Freeman: Of course. Progress was outlined yesterday by the First Minister, during her daily briefing. As of this morning, we have 1,812 identified contact tracers. The strategy involves a new message being sent to the public. Up to now, we have told the public that someone with the symptoms should isolate at home for seven days and someone who is part of that household should isolate at home for 14 days, and that, if someone's symptoms get worse, they should contact NHS 24 or go to the NHS Inform website. From tomorrow, we are saying that someone with the symptoms that we know of should contact us and book a test, using the freephone helpline number or the NHS Inform website. At the point that that contact is made, we will tell the person to isolate for 14 days and that, if the test result is positive, we will be back in touch with them to ask them whom they have been in contact with in the two days prior to their noticing the symptoms, up to the point at which they isolated. That approach involves a different ask of the public. For it to work, it requires significant compliance from them, and it also requires there to be relatively low transmission levels in the community.

The information and marketing around the strategy started to go out yesterday. That will continue, including via door-drop information, so that we can be sure that people know exactly what to do if they have symptoms and what to do if they are contacted as a contact of the trigger case.

We will have those 2,000 contact tracers in place and ready to be deployed from tomorrow. We do not anticipate needing them all, but we hold them in a pool and we will continue to recruit to that number during June.

The testing that was done in the three health boards that you mention involved scaling up the technology to aid the contact tracers. That technology is, at its core, what we have used in the health service in Scotland for other infectious diseases such as tuberculosis and sexually transmitted diseases. It was scaled up and focused on Covid-19.

This is a national health service led operation, which means that the data is held confidentially by the NHS and the Scottish Government has no access to it.

The testing was done to ensure that the system was ready to go, and the results were satisfactory. During June, we will enhance it in such a way that the individual with symptoms can add details of their contacts via a web page—the system is web-based; it does not involve an app—while they are waiting for their test results. That means that, as soon as the result comes back as positive, we will be good to go, subject to some checks to ensure that the person has not missed anybody.

Emma Harper: The contact tracers who have been employed are already NHS employees, so I assume that they have the ability to put a level of competence in contact tracing into practice. For instance, you described how they have carried out contact tracing for tuberculosis. Can you clarify whether those folks are already experienced in contact tracing?

Jeane Freeman: As Emma Harper knows, we started with our existing health protection teams. Every NHS board has those, and they flex their staff numbers up or down, depending on what they are dealing with. In those core health protection teams exists a significant degree of expertise and experience, and we have added to that.

I said that there were three routes to producing the number of contact tracers that we have initially estimated that we will need. The first of those routes was to bring in other NHS staff. The second was to identify individuals in our NHS returners group and to bring them in, and the third was the public advertising campaign. As we work through all those routes, everyone will be trained to ensure that they are up to speed and know what they have to do. That training is for contact tracers and the people who will operate the telephony—the first people the public will speak to—as well as those who are ensuring that the NHS Inform website is constantly monitored and maintained so that it can cope with that demand along with the other demands that are on it.

There is core training and then specific training, depending on the role that people are taking up.

Emma Harper: The test and protect strategy is to find persons who are symptomatic; therefore, it is not part of the strategy to look at getting results of elective surgery or cancer screening online. Can you clarify that test and protect is to find people who are symptomatic?

Jeane Freeman: Yes. A test and protect strategy is used when the transmission levels in the community are low—which they are. The transmission levels are now coming down in Scotland.

The strategy is an essential part of releasing any of the lockdown restrictions. We have brought transmission levels down because of the lockdown, the huge public compliance with it and the sacrifices that that involved. As we release any lockdown measures, we sensibly expect that transmission levels will rise. Test and protect is there to quickly identify where that is happening, track it down, contain the virus and stop it from going any further.

The strategy was described by—I think—Ken Macdonald on "Good Morning Scotland" as "hunting down the virus", and that is a reasonable explanation. Central to it is that it requires that the public comply with it and that they trust that their data is held confidentially. That is why it is an NHS-led exercise and why it is really important that people understand that their data is held under the same degree of protection and confidentiality as their medical records. Government ministers cannot access it; it will be held for test and protect purposes only and then will be held no longer.

Emma Harper: Thank you for that answer, cabinet secretary. I have one final question. What kind of support will the Scottish Government be implementing to enable people to isolate effectively?

Jeane Freeman: Part of the information that we will put out iteratively to people across Scotland—including to every household—will tell people what we are asking them to do if they are asked to isolate. Of course, we are asking them not to leave home at all, for any reason. Therefore, we want them to think a little bit in advance, in case that is asked of them, about who—if anyone, such as friends or family—can help them by providing food, collecting medicines or helping in other ways for those seven or 14 days, depending on what they are being asked to do.

Also, we are expanding the significant operation that public health partnerships have put in place to support the group of people whom we have asked to shield over the past number of weeks. That operation will expand its locus to provide support to individuals who are asked to isolate and could include individuals in circumstances in which it is not possible to isolate in their household—they may not have an extra bedroom to sleep in or there may be other reasons why it is not possible. Each local public health partnership has worked up its plans for how it will be able to offer people accommodation and support in those circumstances for that period of time.

Brian Whittle (South Scotland) (Con): Good morning, cabinet secretary. How important will the contact tracing app be to tackling the on-going pandemic?

Jeane Freeman: Good morning, Mr Whittle. I am not sure exactly what you mean when you say "app". Let me tell you about the digital technology that we will use here, in Scotland. As I said to Ms Harper, it is a piece of digital kit that has been developed from what we have used for contact tracing for infectious diseases in the past. Initially, in its current format, from tomorrow it will assist the contact tracers to do their job. In the course of June, we will add an enhancement to it that would allow you, if you were the trigger case—if you had symptoms and had phoned or gone online to NHS Inform to book a test—to begin to add in through the web, not an app, any contacts that you could remember dealing with in the two days or so before your symptoms appeared until the day that you made the phone call and began isolating.

You may be referring to the UK Government's proximity app, which was trialled in the Isle of Wight. We remain interested in its development, and I understand that the UK Government is

reviewing it. My colleague Ms Lamb may be able to give you more detail on it. However, we have a number of questions that would need to be resolved if we were to offer it for use in Scotland, including whether we could ensure that data from it would feed into our system. Would we get the community health index number and the identifier so that we could find you and whoever the app pinged as being your contacts? I understand that, at the moment, the UK Government is reviewing the result of its trial in the Isle of Wight, to determine what more it might do with the app, so it is not yet available for us to make a decision about whether it would enhance what we are doing.

Brian Whittle: I am looking for clarification so that I understand what is on offer from the Scottish Government. You have a digital platform that will rely on the individual who becomes symptomatic inputting details of the people they have been in contact with. As it stands, there is not a Scottish contact tracing application that will enhance that—am I hearing you correctly, cabinet secretary?

Jeane Freeman: It does not rely on the individual putting their contacts into it—remember that we have contact tracers. However, it gives the individual the opportunity to help us by putting in their contacts without waiting for a contact tracer to get in touch with them. They can do that while they are waiting for their test result.

It is an enhancement; it is not central to the work. The real work is done by the boots on the ground—the contact tracers who are in touch with the person and take them through a series of very important questions about whom they have been in touch with, where they were, and so on. From that, they make decisions not just about the individuals that that person might have been in contact with, bearing in mind the definition—less than 2m for longer than 15 minutes—but about where that person was and whether others who were in the vicinity should be contacted. That does not rely on the individual.

We are not developing a proximity app for Scotland. If the UK Government decides, after its review, that it wants to go ahead with its proximity app, which would work most effectively if it was UK-wide, and if we can sort out the information flows, that would assist across the UK. However, that has not yet been determined.

10:30

Brian Whittle: If I became symptomatic, the likelihood is that I would not get a test. The system would still rely on my logging in to that digital platform and relaying my symptoms so that a contact tracer could come to me. Is that the process?

Jeane Freeman: No, it is not.

I am not sure why you think that you would not get a test. If someone has symptoms, they should do one of two things: use the free phone number or go to the NHS Inform website. Either of those can be used to book a test for them, and, as soon as the result of that test comes back, our contact tracing operation will know what it is.

If the test result was “Brian Whittle: positive”, our contact tracers would contact you to ask about all the contacts that you had had and take you through the whole exercise. They use the digital tool to speed up the process for themselves; it is an aid to their work. The only additional thing that will become available at some point in the month of June is that, while you were waiting for that test result to come through, you could aid the process, using the digital app, by beginning to input your contacts.

It is about speeding up the process, because speed is really important. The quicker we get contacts identified and nailed down, the quicker we will break the transmission chains.

Brian Whittle: I am sorry to labour the point, but it would still rely on my reporting that I was symptomatic and then having someone come and test me before the details would go on to the digital platform. The onus is on the individual. I do not understand why we are not looking at a proximity app to aid with that.

The Convener: Be brief, cabinet secretary.

Jeane Freeman: Yes, it relies on the individual—I think that I said that in my first three minutes or so of speaking. It absolutely relies on the individual, just as obeying the lockdown restrictions relied on individuals. If individuals had not been convinced about obeying the significant restrictions on daily living that they have put up with for a number of weeks, lockdown would not have worked. Of course, it relies on the individual.

The difficulty with the proximity app, as I understand it so far, and why the UK Government is looking at it again, is its sensitivity. There is no value in a proximity app that pings every time I walk past someone. I have walked past them; I have not been within 2m of them or in face-to-face contact with them for longer than 15 minutes. The proximity app is not specific enough to really aid contact tracing. However, that does not mean that it cannot be so, and that is what the UK Government is looking at.

All along, we have said that if we can get to a point at which the app can provide clarity and specificity and can be used in a clear and focused way that does not send contact tracers to trace contacts who are not relevant to the case definition, and if we get the information channels right so that, if the app pings, we know that it is Brian Whittle and we know your CHI number and

that we can get to you, the app will be a significant enhancement to all the work, but we are not at that stage yet. I am sure that the Isle of Wight trial was of value to the UK Government, but the app was not downloaded by a sufficient number of people.

When the app overcomes those glitches, and if it gets the required level of take-up from the public—there is a debate about what level is needed, but it needs to be between 60 and 80 per cent for the app to be effective—we will still not necessarily reach individuals who will not download the app. The central part of the approach, which is our reliance on people telling us that they have symptoms and booking a test, remains, because not everyone will want to download an app on their phone.

The Convener: I have a very brief supplementary question that should require a straightforward yes or no answer. If a contact is identified and traced but does not have symptoms, does that person get tested, or are they simply left in isolation?

Jeane Freeman: Let us imagine that I am the trigger case and you are one of my contacts, because we were closer than 2m apart for more than 15 minutes. You will be contacted and told that you are a contact of a trigger case. You will not be told who the trigger case is—which is a really important point—and you will be asked to isolate for 14 days. If my test result comes back negative, you will be contacted and told that you are fine and that you do not need to continue isolating. You will not be tested, because, at that point, you will not have symptoms, which takes us back to the point about whether there is value in testing asymptomatic people. You will not be tested unless you develop symptoms in the 14 days, in which case we would be off again and we would look at your contacts.

It is important to say that not only will you not know that I am the trigger case but, if Mr Whittle, for example, was another one of my contacts, he will not know that you are a contact, either. In relation to who knows what, all the information is kept siloed—it is good siloing. The only person who knows the whole story is the contact tracer.

David Torrance (Kirkcaldy) (SNP): In order for the test, trace and isolate system to work effectively, tests results need to be delivered quickly. What is the average turnaround time for testing currently and what does it need to be in order to underpin an effective test, trace and isolate system?

Jeane Freeman: We should remember that we have two laboratory systems in Scotland that are currently undertaking testing. We have the NHS lab system, which includes all the NHS labs in territorial boards and the academic partners and others that I mentioned at the start of the meeting, and we have the Lighthouse labs, which are where tests from the regional testing centres go. I will ask Caroline Lamb to confirm the current turnaround times.

On the question of what we are aiming for, our chief medical officer's office tells us that the whole thing needs to be done within 48 hours. We are aiming for a 24-hour turnaround, because speed is of the essence. That is our aim. We do not control what the Lighthouse lab does, but we can ask it to get to that point. That is what we are aiming for in all our labs, with consistency. Some are coming in under, at different times, but we need consistency across them all.

Caroline Lamb (Scottish Government): I confirm that, in our Scottish NHS-controlled labs, we are now consistently achieving turnaround within 24 hours. For the Lighthouse lab capacity—for us, that is largely the Glasgow lab—the most recent figures from the UK Government show that it is now achieving 89 per cent turnaround within 48 hours, with a strong commitment to improving that. Where we have most difficulty is in relation to the Milton Keynes Lighthouse lab, to which the home-testing kits currently go. We do not yet have good data from the UK Government about turnaround times there; we are raising that issue with it.

David Torrance: There is increasing evidence to suggest that asymptomatic and pre-symptomatic people may be infectious. What proportion of cases does the Scottish Government assume are asymptomatic, and are there any plans to routinely test the population even when they have no symptoms, or certain people such as key workers and care home residents?

Jeane Freeman: I think that the information on where we are on surveillance testing will probably answer the first part of your question. The most recent results from the current surveillance testing programme estimate with a 95 per cent confidence interval level that the true figure for the proportion of individuals in the community who have the virus, based on the swab testing programme that we talked about before, is currently—it changes over time—between 2.9 and 7.5 per cent. That relates to individuals who are not necessarily symptomatic but who we are, if you like, spotting through the surveillance testing. That surveillance testing will continue; it will not stop. It needs to keep going, because it helps us to understand the level of the presence of the virus in the community, alongside what we do with the test and protect strategy.

I apologise—I have forgotten the second part of your question. Could you remind me of it?

David Torrance: Are there any plans to routinely test the population even when they have no symptoms, or certain people such as key workers and care home residents?

Jeane Freeman: You will recall what I said at the start about asymptomatic individuals and the current debate about the accuracy of the test in those situations. You will know that we have introduced testing for care home workers in care homes where there is no active case. That is a precautionary measure to try to prevent the introduction of the virus into those care homes as far as we can.

However, that requires testing to take place every seven days; we have to keep repeating it, because all that the test does is tell us whether someone has the virus at the point at which the test is taken. Although we could test 20 care home workers as negative, we cannot then assume that everything is fine; we need to go back in seven days and test them again, and we need to keep doing that.

There is discussion around that. I have asked the chief medical officer's office for advice on the testing of health workers in healthcare and in specific settings. Although there is certainly a planning assumption for testing capacity that would allow us to cope with that, I need the view of the chief medical officer's office and of his scientific advisory group, which is chaired by Professor Andrew Morris, on whether there is a value in that and whether that value is general or applies to specific settings. Finding out whether we should do it in particular parts of the healthcare setting, in order to give us additional confidence about restarting elective work or any other area of health, is particularly relevant as we work to restart areas of the health service, as Mr Torrance has mentioned.

Miles Briggs (Lothian) (Con): Good morning, cabinet secretary. The First Minister has accepted that the care home transfer policy is likely to have contributed to the death toll that we have seen among the residents of care homes. Given what we knew was happening in care homes in Italy and Spain, why were new care home residents not tested on discharge from hospital?

Jeane Freeman: I will say two things about that. First, testing, in and of itself, is not the only precautionary measure that should be taken. I am sure that Mr Briggs recalls that we issued guidance to care homes on 13 March, which advised them of the measures that we needed them to take to reduce the risk of transmission inside the care home. The guidance at that point included that communal activity should end or levels thereof significantly reduce; that residents should eat in their own rooms; that infection prevention and control measures should be ensured; that personal protective equipment should be used; and that visiting should be stopped, with some exceptions. Alongside testing, all those measures contribute to preventing the transmission of the virus, and I argue that quality infection prevention and control, which includes the right use of PPE, is essential to that.

Secondly, the member knows that we subsequently introduced specific requirements on testing in advance of admission, which came as a consequence of our increasing knowledge of the virus. I have said before that, looking back at decisions that I took individually or as part of the Government at various points on this journey, from the start of this year through to today, had I then had the information, knowledge or experience that I now have, I am sure that I might have made different decisions. I did not have hindsight then—I have it now. As I acquire knowledge and increased understanding, and as advice changes and I recognise the difference that it might make to what we are doing, I need to adapt what we are doing to incorporate those factors.

Miles Briggs: Given what the cabinet secretary has just said, is it fair to say that the priority was to free up NHS capacity and not necessarily to put in place the safeguards that could have been in place for care home residents?

Jeane Freeman: It is an interesting point, because I have recently looked at the statements that I made in Parliament in March on an almost weekly basis. In my first statement of 3 March, I gave the numbers that had come from scientific advisory group emergencies modelling on the estimated worst-case scenario, which is what every nation of the UK was working on at that point. I am sure that the member will recall that the estimate said that 80 per cent of the population would be infected by the virus, of whom 4 per cent would require hospitalisation, including ICU.

Those figures meant that we had to significantly scale up the health service's capacity in order to prepare for, and cope with, that volume of cases. Having looked at the experience elsewhere, we did not want to find ourselves overwhelmed by cases, because that would mean that those individuals could not get the treatment and clinical care that they needed.

In that statement and the statements on 10 March and 17 March, I set out what that meant in terms of initially doubling our ICU beds then tripling them—we are now working towards quadrupling them and creating that 3,000-bed capacity—stopping elective and other procedures; and improving on delayed discharge of those individuals in hospital who were clinically fit to be discharged but who had been delayed beyond their discharge date because care packages were not available for them either in the community or in

care homes. My recollection is that that was where our focus had to be. We did not ignore care homes. We were conscious of them. The first piece of guidance came out on 13 March and it was approved by the chief medical officer and Health Protection Scotland and others, and we went from there.

Looking back from where we are now, I do not think that I am the only one who thinks that, if I knew then what I know now, we might have taken a different view or an additional view. That is where we were a short time ago, and that is the approach that we took. At that point, it was a collective approach across the four nations of the UK.

The Convener: Thank you. I remind members that we will have another session on care homes with the cabinet secretary in the near future.

David Stewart (Highlands and Islands) (Lab): I want to move on to talk about antibody testing, which can tell, with various degrees of accuracy, when someone has previously been infected with the virus. The cabinet secretary will be aware that, earlier this month, health officials in England made a breakthrough with the Swiss company Roche, which developed a new antibody test. The health official described that as a positive development. When will we see mass antibody testing here? Does the cabinet secretary have specific procurement plans, bearing in mind that the test has been approved in the European Union and in the US?

Jeane Freeman: A lot of work is being done on different kinds of antibody test. The serology testing—the blood antibody testing—that is under way here in Scotland started on 6 May. It is being led by Health Protection Scotland and involves samples that have been taken from six mainland boards as well as samples that have been taken from smaller NHS boards. It uses samples from blood that was taken for other reasons, and it is described as pseudo-anonymised.

We should remember that it is still early days, but it is showing us a 95 per cent confidence level, which indicates that the proportion of the population that has antibodies is between 3.4 per cent and 13.6 per cent. That is a wide range, and the more testing is done, the more it will begin to narrow that range, although it will always be a range.

The other issue around antibodies, apart from identifying whether people have them, is knowing for how long people have them. If we think about another coronavirus—flu—I am sure that most of us at some point in our lives have had the flu, but that does not protect us and prevent us from getting the flu again, because flu strains change.

Antibody testing is important, but it is not a silver bullet. There is much more to do to understand whether having the antibodies protects us against the virus and, if it does, for how long.

On the question of the UK Government's announcement of antibody testing for health and social care staff and patients in England and its deal with Roche Diagnostics and Abbott Laboratories, we are engaged with that issue. Some antibody testing of healthcare staff has been going on in Scotland—you might have seen some of the media reports about that. That testing needs to happen to settle on the antibody test that gives the greatest certainty in its results—a certainty equivalent to the effectiveness of the PCR test—and then plans need to be worked on to use that and introduce it.

All that work is under way with our chief scientific officer, Professor David Crossman, as well as work that contributes to vaccine development and so on. We have an eye on the work that is under way and an eye on what we might need to do to procure a vaccine and put it into our programmes. As you know, we have an extensive vaccine programme in Scotland, and that would become part of it. We would build on that, but that is where we are at the moment; we have a very close eye on it, we are watching its development and we are ready to plan to use it when one of the antibody tests comes through with less uncertainty around it than they all currently have.

David Stewart: I will ask a question about the bigger picture. Do you agree that antibody testing, to use a military analogy, is a second front? We have antigen on one side and antibody on the other. If we look at the bigger picture of what is happening across Europe, we see that Germany had more than 61,000 antibody tests last week and Spain had around the same. How many antibody tests are you carrying out in Scotland? In the long term, bearing in mind that Roche argues that its test, following the Porton Down facility evaluation, is 100 per cent correct in identifying people who have been infected, do you envisage the development of what would in effect be immunity certificates for front-line key staff such as NHS and care staff and police. I appreciate that there is some controversy about that, but I am looking at the long term when antibody testing could be a crucial tool in getting us out of this deadly pandemic.

Jeane Freeman: My general answer is that I would not rule that out—that does not mean that I am ruling it in, but I would not rule it out. That is partly because there is genuinely a degree of controversy and partly because there are some ethical issues to work through; it is also related to my point about how long people might have

immunity. We do not yet know whether Covid-19 is going to behave in the way that the virus that give us the flu behaves, with new strains emerging—the fact that you had flu last winter will not protect you from getting flu this winter. Remember, flu is a coronavirus and the common cold is a coronavirus.

The degree to which any antibodies that you have and the level to which you have them protect you from acquiring Covid-19 and for how long are important questions to ask and answers to which will come from all the research and work under way globally, including Scotland and the rest of the UK. That is why I am not ruling antibody testing in or out. There is a degree to which we can be confident about the efficacy and the longevity of those kind of tests in terms of what they tell us, and there are those ethical questions, so I would not dismiss it, but we need answers to some of those important questions.

11:00

George Adam (Paisley) (SNP): I want to ask about travel. My question has probably taken on a different perspective given the events in the past couple of days. Part of the success of the lockdown in protecting our communities is the discipline that the public have shown over travel restrictions. Do you share my disgust and that of many of my constituents when we hear of a senior UK Government figure taking a 250-mile jolly with his family? Let us not even talk about him testing his eyesight by taking a 30-minute drive, which was when Dominic Cummings became the real-life Mr Magoo. Do you agree that it is disgusting that someone in such a senior position would abuse that position?

Jeane Freeman: All of us who are in positions of influence—whether that is you, Mr Adam, as an MSP, and your committee colleagues, or me as an MSP and in my role as cabinet secretary, in which I not only have influence but make decisions—have an absolute responsibility to exemplify the behaviour that we are asking others to show. We have asked people to comply with serious restrictions. I know that, like me, you will have constituents who have had to take genuinely heartbreaking decisions not to be with those they love or who have had genuine worries about how they will look after their dependants if they are ill. Collectively, all of us who occupy such positions have a serious responsibility to abide by the rules that we ask others to follow and to model that behaviour.

As I said when asked about the issue previously, I have a real concern that the message that could go out is that the restrictions and what we are asking people to do are somehow negotiable or are on a "take it or leave it" basis. For example, as Mr Whittle touched on, if members of the public have symptoms of the virus, they must now contact us, book a test, isolate for seven days and tell us about their contacts. That is a big ask of the public. If they do not do that, as we ease the lockdown measures, the incidence of the virus in the community will rise, and there is a serious risk of a second wave and that all the gains of the past three months will be lost.

What happens to an individual in those particular circumstances is not for me to decide, but it is a serious matter that is to be taken very seriously indeed.

George Adam: Many of my constituents have become quite upset regarding their situation. What would you say to them? They have followed the rules and done everything correctly, but, because of the message that has been sent out, they are now asking whether they can drive to a holiday home, go and see their dying relatives in hospital or do other things differently.

Jeane Freeman: To individuals in those circumstances, I would say, "Please do not do that. You have achieved so much by what you have done and I do not for a second underestimate what that has cost you, but what you are doing is not just about protecting yourself and your family; it is about protecting your neighbour and your neighbour's neighbour, and what they do protects you." The approach requires us to think not just about ourselves but about others. Professor Reicher from the University of St Andrews, who is a member of our CMO's advisory group, put it really well when he said that we are asking people to think about the "we" and not the "I". That really matters.

I am hugely grateful to the percentage of the Scottish population who have been complying with the lockdown measures and who intend on continuing to do so. If we are not successful in that, we will not be able to control the transmission of the virus, which will have serious consequences for people's lives. That is not hyperbole, nor is it dramatic; it is simply a statement of the facts.

George Adam: Different countries have taken different approaches to inward travel during the pandemic. New Zealand banned inward flights from China early on. What powers does the Scottish Government have on inward travel? Will arrivals be tested for the virus? If so, what form could that take? As the cabinet secretary has already explained, there have been questions about the various testing methods.

Jeane Freeman: We do not have the powers to control borders; the UK Government determines that. The Border Force is not under the locus or the remit of the Scottish Government. The UK

Government has now said that it intends to impose restrictions on travellers who are coming into the UK. We are working with it to understand the details of those restrictions and to ensure that, where there is a requirement on us through our devolved powers, we are prepared and ready to deliver on that requirement. It is for the UK Government to decide on the nature of the restrictions that are imposed.

We are working to understand the restrictions, which will affect all the nations of the United Kingdom, and are feeding our views into a four-nations discussion. We are also considering whether we can reach an agreement about what those restrictions should be and what should be asked and required of inward travellers, remembering that some will be citizens who are returning home.

We need to work out all the detail. As with everything else during the pandemic, it is important that the work continues at pace. We will be able to provide more details about what we are doing and the UK Government will provide details about what it requires from inward travellers in the near future, I would imagine.

Sandra White: Before I turn to Sandra White, Emma Harper has a brief supplementary question.

Emma Harper: Thank you, convener, for taking my supplementary question. At last week's Rural Economy and Connectivity Committee meeting, when Maureen Watt asked Michael Matheson, the Cabinet Secretary for Transport, Infrastructure and Connectivity about the consultation that had taken place with the Scottish Government on travel, he responded that there had been no formal consultation. I am therefore pleased to hear that the UK Government is now working with the Scottish Government.

One issue that the Cabinet Secretary for Transport, Infrastructure and Connectivity raised was that of quarantine for people who come into the country through Heathrow airport and then have to travel on to Aberdeen, Glasgow or Edinburgh. Is that part of the discussion? It is very important that the Scottish Government is included in forward-planning discussions. For example, the border at Gretna is 30 miles along the road from me; there is also the border at Cairnryan, where Europeans can arrive and travel through the UK. Those are some of the real issues that make it necessary for the Scottish Government to be included on the discussions about inward travel. I would appreciate your thoughts on that.

Jeane Freeman: My opinion is that we have not been overly involved—or as involved as much as we would have wanted to be—in those discussions. This is not just about Glasgow and Edinburgh airports; it is also about what happens at Heathrow, Manchester and Newcastle airports and at our marine ports.

There has been engagement between officials. The First Minister, along with other devolved Administration First Ministers, has had at least one call with Michael Gove. I am not aware of other calls—there may have been others—but I am aware of one call in which some of the issues that I have rehearsed were raised and in which there was a commitment that the discussion would continue. That is, as far as I know, where we are at this point, although that does not mean that I know everything about where we are at this point.

Sandra White (Glasgow Kelvin) (SNP): Good morning, cabinet secretary. Before I ask my questions, I want to add to what George Adam said. People really need to be aware that the guidelines that Dominic Cummings quoted were put into the Covid-19 guidance late on by the National Society for the Prevention of Cruelty to Children in order to protect mothers and children who are fleeing domestic violence. That is a strong point. It is absolutely unforgivable for anyone to hide behind those guidelines.

My questions are about the quality and the location of testing. The committee papers refer to evidence that we have been given about unregulated volunteers carrying out swab tests and that children are being asked to take their own swabs. I looked up the organisation's website, and it mentions lab experience and the provision of full training and PPE. Will you clarify that, please?

Jeane Freeman: I do not know where that evidence came from. The testing that is controlled by NHS Scotland does not use volunteers or children; that testing is done by properly qualified individuals. Of course, individuals might be asked to take their own test—that is the home test kit, which is currently available in a limited capacity and not in every part of Scotland. The kit is delivered to a person's home with instructions on how to use the swab and take the sample. Taking the sample for that test is intrusive. A person has to stick the swab quite far up their nose. If they are doing it to themselves, they may be tempted to stop when it begins to be a wee bit uncomfortable. I am afraid that that is not far enough—they need to keep going.

There are some concerns about individuals doing their own tests. My understanding of the UK Government's regional test centres is that, on occasion, if not in every instance, the individual who drives up to the test centre at their appointed time is asked to take their own swab under guidance. They are not on their own in their own home, and they are given guidance. That approach is also used in the mobile units, which are staffed by the armed forces. We intend to use the mobile units in our care homes, where they will

be supplemented by appropriate clinical staff from the local NHS, who will apply the swab to get the sample for the test.

Sandra White: I checked that out on the website, which said that full training and PPE is supplied; it also mentions lab experience.

You mentioned the drive-through centres, which I have been led to understand are UK-wide. We know that there has been training in Scotland, because that is mentioned on the website, but has training and quality assurance been carried out in any of the testing centres?

11:15

Jeane Freeman: You are absolutely right, Ms White; the drive-through centres are part of the UK Government programme. We have a number of drive-through regional testing centres now. The latest one, at Prestwick, is due to open this week, which will free up one of the mobile units for us to deploy elsewhere—so that will happen.

I should say, in response to your earlier question, that PPE is critical in those situations and the staff who apply swabs and get the samples should be properly equipped with PPE.

Caroline Lamb is probably best placed to talk about what quality assurance checks are put in place at testing centres.

Caroline Lamb: We have established a clinical assurance group in Scotland to oversee the UK testing programme. That group would identify issues and seek to resolve them, working with UK Government clinical colleagues.

It is probably worth pointing out that we now have a draft memorandum of understanding between the UK Government and the Scottish Government, the details of which we are currently working through and considering, to make sure that we are entirely happy with all the arrangements that it sets out.

Sandra White: Thank you, that is useful to know. Perhaps when that is done, the memorandum of understanding will be made available to the committee. I can see that the cabinet secretary is nodding her head, so I will take that as a yes.

I was interested in what you said, cabinet secretary, about the Scottish Government's 24-hour turnaround time for tests and the UK Government's 48 hours—the longest times are more than 48 hours. I was intrigued to hear that the home testing kits go to the Milton Keynes lab, which gives rise to concern about the timescales. Will you clarify that point?

We have mobile units and so on, but will there be more testing in the community, for example at pharmacies?

The Convener: Cabinet secretary, perhaps you could verbalise your agreement to supply the memorandum of understanding.

Jeane Freeman: I am happy to do so, convener. When the memorandum of understanding has been agreed and finalised I will send it to you to share with the committee.

Caroline Lamb can talk members through the Milton Keynes issue, including how we make sure that the data from the home tests that are undertaken in Scotland feeds back into our system, which is important.

I should mention the saliva test that is being trialled. Members might have seen media coverage of the trial in a part of England. Work is also under way in Lothian—it started a week ago, on 19 May—to compare saliva samples with nasal swab samples and determine whether the saliva test, which is obviously a less invasive and much quicker test, is comparable in efficacy with the nasal swab test.

On where people can get tested, I am conscious that simply telling people to go to the drive-through centres is very limiting for many individuals: not everyone has a car—I do not know the exact numbers but I think that more than 20 per cent of people in Scotland do not have their own vehicle; people might be unwell, and driving with any degree of impairment is never advised; and there might be some distance to go to get to a regional testing centre. Therefore, we are actively looking at what else we might do—nothing has been finalised—including the possibility of using our existing Covid-19 assessment centres. Members will remember that we set up a community-based Covid-19 pathway in order to ensure that general practitioners could continue to treat their patients who did not have Covid-19 symptoms but had other healthcare needs. Those assessment centres and hubs remain and will continue, whatever else might be possible.

We are also looking at our options for other community and high-street based testing areas, again while making sure that individuals who have Covid-19 symptoms are not asked to travel far and that others who use those premises are protected from transmission of the virus—we need to be careful in that regard.

We are considering our options for taking the test to an individual's home when, for any of a number of reasons, they cannot easily leave their home at all. For example, a single parent might not be able to leave the house because they have no one to look after the children, or someone might be physically impaired or elderly.

The final option that we are considering is providing transport for individuals to testing areas, to ensure that they can be tested as quickly as possible.

The overall objective is to make testing as simple, straightforward and easy for people as we possibly can, because we know that we are asking a lot of them. We want to remove as many obstacles as possible to doing what we want them to do, which is to get a test and give us their contacts.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, cabinet secretary. Funnily enough, I have a range of questions that spin out of the answers that you have given previously.

The first one is related to the last sentence that you said. The concerns that have been expressed to me by constituents are about getting to the testing centre at Edinburgh airport—those concerns have mainly come from key workers, who, I am told, until now have been the only people who could go there.

You said that you are looking to institute transport options, but it strikes me that, for the scheme to work in a way that ensures that everyone who needs to be tested can be safely tested, we need to have that transport in place now. What do you envisage that scheme looking like? Will it use specialised taxi firms, patient transport or something else?

Jeane Freeman: There are various options. When I say that we are considering them, please do not take that as meaning that we are going to consider them for a while before we decide anything. What I mean is that final decisions are not being made at this time, on this Wednesday morning. They might be made by this time tomorrow morning, or they might not be, but we understand the need to move at pace and to get these final bits of the process quickly decided on and put in place.

You will recall that we had a very kind offer from Arnold Clark to make available a number of its vehicles. That offer has been taken up—we have used some of them—and the offer remains. There are black cabs, which, of course, have protection between the passenger and the driver as standard. Black cabs are not being used much at the moment because of the nature of the restrictions, and they are not likely to be used significantly more in the immediate period, so discussions are under way about using them.

We are also having discussions with our Scottish Ambulance Service about whether it can do anything, bearing in mind, however, that we are looking to restart parts of our health service that require patient transport, so there is a limitation on what we should be asking of our ambulance service.

As important as that area are the questions of how many other locations we can safely offer for testing that are close to people's homes—a short walk away—and what our capacity is to offer testing at home, so that the test comes to the person. All that work is well under way. I expect that we will be able to make decisions on all those areas in the very near future, and as we do that, those decisions will inform the information that we put to the public, the marketing campaign and so on. The offers that are made to people when they phone or get in touch to book a test by any of the ways in which that can be done will be added to iteratively as we bring them on stream, and we will of course ensure that the committee knows what they are.

Alex Cole-Hamilton: Thank you. I move on to testing of people with additional support needs and those with dementia. I have had two tests, and they are brutal. They are not comfortable at all. For the scheme to work, anybody who exhibits symptoms—they may have been on an outing or to the shops or whatever—will need to be tested to have it established that they have Covid before the contact tracers can do their work. Will specific provision be made for the testing of people with additional support needs and those with dementia, who might be distressed by the physicality of the test that we ask them to undertake?

Jeane Freeman: That is a really important matter, and it is currently an issue in our care homes. There may well be occasions when it is not possible to administer the test because the distress of the individual is too great. In those instances, we need to find other ways to prevent transmission. That might involve our presuming that the person is positive and beginning to trace their contacts regardless. We might decide not to test them, because the test would be way too distressing for them. In such a case, in the absence of a positive test, we will try to identify all the places that they have been to and seek out their contacts on that basis.

If the individual is a contact of someone with a positive test, we will require that they isolate at home or wherever they are for the 14 days, the same as the other contacts, bearing in mind that that is not straightforward in such instances. We need to ensure that, as well as the support that I talked about earlier, there is a version of the support for our shielding programme. We need to put good-quality clinical support into such situations and ensure that our local health protection teams, who are running this operation for the health service, can access that.

Alex Cole-Hamilton: My final question is about contact tracing. How deep a dive will contact

tracers do into people's movements? Do you envisage a time when they may need to look at store closed-circuit television footage, transaction history or things like that? If they fear that a major outbreak may be on the way, will they dig that deep?

Jeane Freeman: By and large, they will decide that on the basis of what the individual tells them about their contacts. We should remember that it is an iterative discussion with the individual. Let us imagine that I was being contact traced about what I have done so far this morning. I would describe leaving home, and the contact tracer would want to know who was at home and how I got from Glasgow to Edinburgh. They might ask, "Who were you with? Did you stop at any point? Did you speak to anybody? Did you call in at a service station and pick up a sandwich or whatever? Did you stop at any point on the journey? When you arrived here at St Andrew's house, what did you do? Did you stop and speak to anybody before you got to your office? Who were you with? Who did you talk to and for how long?" It is not an interrogation, but they will keep going in a skilled way in order to get the maximum information.

If, for example, I told them that I had come through on the train, they would want to know where I was sitting and look at what else was going on in the train. They might ask me, "Who was near you? Did you speak to anyone on the train?" I got off at Waverley station. They might ask, "Did you just walk straight through Waverley and come up the stairs? Did you go into a shop and buy anything? Were you in a queue?"

11:30

By the way, that scenario is weeks ahead of where we are in terms of the restrictions that have been lifted, but you can imagine the situation.

Obviously, if I had queued and been served in a shop, I would not know everyone who was in the queue with me and we might not be 2m apart. That would depend on how good the shop is at doing its job and how well I am complying with social distancing. The contact tracers may then look at other sources of information to help them identify that.

The contact tracers need to determine what information is required. You need to remember that they are health protection teams, led with clinical input from Health Protection Scotland, who are well skilled and experienced in that exercise. They take the lead and make the decisions, including on whether they consider that they have identified a cluster or an outbreak and what they then do on wider notification about that.

The Convener: I have a final question on sentinel surveillance, which is a way of using testing to establish the incidence and prevalence of the infection. The basis on which some of that is done may have changed over the past couple of months. Are there any outputs from sentinel surveillance yet? Is it giving us a better idea of the incidence and prevalence of the infection?

Jeane Freeman: Earlier, I gave a figure on community enhanced surveillance. The most recent estimate tells us that, with a 95 per cent confidence interval, incidence in the community is between 2.9 per cent and 7.5 per cent.

The figure on enhanced surveillance in the community is very important. The figure that I have given is the estimate at the beginning of May. We will get other data as go through this month and into June, and as lockdown measures are eased. The figure, as well as the numbers of cases, positive tests, hospital admissions and so on, will begin to show us what the set of decisions that the First Minister will announce tomorrow has done to the prevalence of the virus in the community and whether that then permits the next step to be taken at the next review period. All that information comes in from those different sources, and that informs our judgment. As the First Minister has said, it is politicians who need to make the decisions and the judgments on the basis of that advice.

The Convener: Thank you for your evidence, which is helpful and much appreciated. We will no doubt follow up on one or two points. I also thank Caroline Lamb for taking part.

That concludes the public part of our meeting. At our meeting next week, we will consider other aspects of the Covid-19 crisis. Information about that will be made available in the *Business Bulletin* and via the committee's social media.

11:33

Meeting continued in public until 11:52.

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