OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Committee

Wednesday 10 June 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 10 June 2020

CONTENTS

COVID-19 COMMITTEE
9th Meeting 2020, Session 5

CONVENER

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

DEPUTY CONVENER

*Monica Lennon (Central Scotland) (Lab)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Annabelle Ewing (Cowdenbeath) (SNP)
*Ross Greer (West Scotland) (Green)
*Shona Robison (Dundee City East) (SNP)
*Stewart Stevenson (Banffshire and Buchan Coast) (SNP)
*Adam Tomkins (Glasgow) (Con)
*Beatrice Wishart (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Crossman (Scottish Government)
Susie Fitton (Inclusion Scotland)
Professor Roger Halliday (Scottish Government)
Dr Donald Macaskill (Scottish Care)
Dr Gregor Smith (Scottish Government)

CLERK TO THE COMMITTEE

James Johnston

LOCATION

Virtual Meeting

Scottish Parliament

COVID-19 Committee

Wednesday 10 June 2020

[The Convener opened the meeting at 09:00]

Easing Lockdown Restrictions

The Convener (Murdo Fraser): Good morning, and welcome to the ninth meeting of the Covid-19 Committee. We have one item on our agenda today: options for easing the coronavirus lockdown restrictions. We will take evidence from two panels of witnesses.

For our first evidence session, we are joined by Scottish Government officials: Dr Gregor Smith, the interim chief medical officer for Scotland; Professor David Crossman, chief scientist, health; and Professor Roger Halliday, chief statistician and joint head of the Covid modelling and analysis team. I welcome all three and thank them for their time.

When members ask questions, they should indicate who they want to answer. If any witness wants to bring in a colleague, they should say so at that point to allow broadcasting to switch on the appropriate microphone. I remind members and witnesses to pause to allow broadcasting to switch on microphones.

I invite each witness to briefly explain their role.

Dr Gregor Smith (Scottish Government): Good morning, and thank you for the invitation to give evidence. I am Gregor Smith, the interim chief medical officer for Scotland, a role that I have had since early April. Before that, I was the deputy chief medical officer.

My role is to provide and co-ordinate the clinical and public health advice to the Scottish ministers and policy officials. We do that through a network of advisers, some who work directly for the Scottish Government and others who are linked through national health service roles. That structure has been augmented during the response to Covid-19. During the questioning, we might touch on how that advice is provided.

I will hand over to Professor David Crossman, who is the chief scientist, health. He will outline his role in Government.

Professor David Crossman (Scottish Government): In non-Covid times, my role is predominantly one of advising and leading the chief scientist office, which is the office that oversees research, development and innovation in the NHS in Scotland. I am predominantly research-facing; I advise on health research. There is a research interface with the Covid problem, so I have been drawn into that in Covid times. My background is as a clinical scientist—I was a researcher—and I am a cardiologist.

Professor Roger Halliday (Scottish Government): My role in the Government is as the chief statistician for Scotland. I am responsible for the numbers that come out of public sector organisations and for their trustworthiness, quality and impact. I am the interim chief executive of an organisation called Research Data Scotland, which helps organisations to access secure data for the public good and I am also the head of the Scottish Government's Covid modelling and analysis team, which supports decision making in Government and in the wider public sector by developing models that show the potential path of Covid in different circumstances to help planning but also evaluation of policy options.

The Convener: Thank you; it is helpful to understand the respective roles of the witnesses.

I have two questions for Gregor Smith—if you want to bring in your colleagues, Dr Smith, please do so. We are focusing this morning on the issue of easing the coronavirus lockdown restrictions. You have only to switch on a television or a radio or pick up a newspaper to see how much public interest there is in that issue and in how it is progressing. There is a lot of discussion around all the different factors that are at play, such as the R number, the number of cases in hospital at the moment, the number of infectious cases in the general population and the success of the test and trace initiative.

The committee is interested in trying to understand whether the conditions around relaxing restrictions and moving on from phase 1 to phase 2 and subsequent phases are driven purely by the science, or whether they are ultimately political considerations. If you could give us an understanding of the extent to which those aspects are involved, that would be helpful.

Dr Smith: The basis of why the restrictions that we have all been living with for many weeks are in place is that they are designed to try to protect us from the harmful effects of Covid-19—the disease that the SARS-CoV-2 virus causes. The restrictions are designed to separate people from each other in a way that prevents the virus from being transmitted.

Over this time, one of the things that we have done successfully is suppress the spread of that virus. We know that because we monitor various data streams to see exactly what the current state of spread and illness across the country is. Roger Halliday might want to touch on some of the models that we use to do that.

Given that that is the reason why the restrictions are in place, as we start to change those restrictions and to evolve our approach, we need to do so in a way that is safe for the population. We must be clear that that purpose has to remain the focus as we change our approach and we have to make sure that the impact of each change does not cause or allow the virus to spread again.

One of the points that I want to get across is that the margins in that regard are rather tight. Murdo Fraser is right that we have all become familiar with the R number, which is something that probably few of us regularly spoke about prior to the pandemic. However, we have all become rather expert on what the R number is and what the current state of play is—not only in Scotland but in places across the world. That R number is important, because it tells us the potential of the virus to transmit across our communities. However, although it is a useful measurement, we should not view it in isolation, because we also have to take into account the number of infectious cases that we have at any one time and what the burden of disease is within our communities. That tells us what the potential for spread is within the country. The more infectious people we have, the more likely it is that, if the R number starts to rise, we will once again start to see those exponential growth rates that we saw in late March and the early part of April. We want to guard against that, because the margins are extremely small.

For some time now, there has been a sustained and stabilising effect in those numbers, which has given us increasing confidence that changing the restrictions will not allow that rapid growth in the number of cases again. However, I have urged caution all along, and we need to take those steps carefully and assess their impact, rather than do anything too quickly. One of the worst things that we could do after enduring restrictions for many weeks is to move too quickly and find that we lose control of the transmissions in our community and start to see growth in the disease and in the number of infectious cases, which, of course, puts pressure on the ability of services to be able to respond in a way that is helpful.

At all times, the advice has been to use the science to help guide us out of the situation, and to use the data that is available to help us make those decisions in a timely way, always with the purpose of preserving public health.

The Convener: You mentioned the R number. A lot of my colleagues want to pursue that in a bit more detail, and we will get on to that in a moment.

We have moved to phase 1 of the relaxation of restrictions, and the First Minister will make a statement next week about whether we can move to phase 2. In your view, where does the R number have to be before we can safely move to the next phase?

Dr Smith: I would prefer the R number to be stable. If it is stable and improving, that is even better. In terms of absolute numbers, we are looking for a range that R appears in, rather than a single number. Over time, we can see the development of trends in that R number that allow us to get a sense of whether we have a stable picture with a declining number of infections.

It is important that R is taken in context. We would not use R alone in making those decisions. R is important, but we must view it in the context of the pool of infectious cases across the country, and how those cases are impacting on services. Professor Halliday might want to say a little more about that, and about some of the modelling work that he has done that helps to inform those decisions.

Through the models that we work with, and through seeing the experience of other countries, we can start to calculate some of the possible impacts of changes that we might propose, both on the R number and on the pool of infected cases.

Professor Halliday: Gregor Smith mentioned different options for easing the restrictions, and the role of my team is to assess the impact of each option on the R number or on increased transmission.

First, we have been looking at what other countries have done. We are tracking data from about 20 countries around the world. We can look at their experience and at what happened to the R number in those countries when they introduced easements of different kinds, such as the reopening of the schools in Denmark or the restarting of construction in Spain. To do that, we need to consider the situation in the period on either side of the restriction being put in place and we need to wait a few weeks to make sure that we see the effects of the easement. We can do that for some of the things that we are looking at, and that gives a pretty good signal.

When that information is not available, we can take advantage of the fact that we are part of the United Kingdom network. We are linked to SAGE, and to the scientific pandemic influenza group on modelling—SPI-M—which has expert modellers from around the UK who are looking at the impact of various interventions. In particular, we have used the expertise from around the UK to inform our thinking on schools.

When neither of those approaches is possible, we have ultimately considered the five key drivers for transmission. Two of those relate to scale. The first involves how many people are changing their behaviour under an option—whether it is just a few

who are doing something differently, or a lot. The second involves how many people those who change their behaviour come into contact with—if it is not very many, that is a good thing.

09:15

The other three drivers relate to the transmission of Covid by an individual. The first one involves the intensity of any contact that someone has with somebody else. We know that transmission is much higher if, for example, people stay within 2m of somebody else for more than 15 minutes. Secondly, we know that transmission is much higher indoors than outdoors, so that is important with regard to things such as travel to work, school or an activity. Finally, we know that Covid is often transmitted through touching communal surfaces.

We assess the extent to which each of those five drivers applies to a particular option. I am also working with colleagues across Government who are examining other harms that are related to Covid—non-Covid health issues and societal and economic issues—and the benefits of choosing particular options to ease restrictions. That collective advice is then put forward to ministers.

The Convener: Across the four nations of the UK, we have slightly different approaches to relaxing lockdown. Other parts of the UK are taking a probably more liberal approach than we have done so far in Scotland. How actively are you following what is happening in other parts of the UK, learning from their experience and using that information to help ministers here to take decisions about the impact of relaxing restrictions?

Professor Halliday: We are looking at what is happening in other parts of the UK and, as I said, we are working with scientific advisers through SAGE and SPI-M.

As I mentioned earlier, in order to see whether a particular easing is having an effect on the R value, we need two things to be happening. First, in order to know that the effect is down to one thing in particular, we need nothing else to be happening for a week either side of that. The second thing that we need is to wait for about three weeks after the easing has been put in place. We are looking across the UK at some of the changes that are happening, but they do not meet either of those criteria, so it is difficult to see their effect on the R value.

As Gregor Smith mentioned, our assessment also takes into account indicators in Scotland and elsewhere, such as the number of cases, the number of admissions to hospital and the number of deaths from Covid.

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): Dr Smith referred to the experience in other countries, and we have just heard Roger Halliday—to whom my question is directed—talk about looking at what is going on in 20 other countries. I have a personal interest, because I have a nephew who is a senior teacher in Denmark, and I also have relatives in other countries, including Sweden, Australia and the United States.

I particularly want to understand—as a layperson, I stress—how we normalise the data that comes from other countries. How do make sure that it is telling us the same story? We know that things are counted and allocated in different ways in different countries.

I ask that because I want to know the extent to which looking at what is happening in other countries helps policy makers and ministers make decisions based on those countries' experiences. If the data is not comparable because it has not been properly normalised, we will make false decisions. Can you give me a quick layman's view of how we are sorting out the different ways that countries count and allocate their data? That would equally apply to the jurisdiction of the UK, but I am more interested in the situation with regard to other countries.

Professor Halliday: I have drawn together a team of experts from across the public sector and some academics that we are working with. What we are looking for, internationally, is a signal. We model primarily using deaths data, because that is the best, most comparable and most consistent data over time. That consistency over time is really important in order to understand a signal. Even though countries might count deaths in slightly different ways, it is the fact that they are counted consistently that is important for our understanding of whether the easing of certain restriction measures has an effect.

Monica Lennon (Central Scotland) (Lab): It will probably not surprise you that my first question is on the R number. Does the Scottish Government hold information on the suspected R number for different parts and regions of Scotland? If so, is that information shared with health boards or local authorities, for example? Is there any reason why it could not be shared with the public? Perhaps Professor Halliday is the best person to answer initially.

Professor Halliday: Calculating the R number is not straightforward. Statistical modelling is used to do that. As such, a level of uncertainty is introduced. My advice is to class it not as a number but as a range, as Gregor Smith mentioned, which is currently between 0.7 and 0.9. That is still a decent-sized range.

If we were to look at local areas, we would be dealing with much smaller numbers—for example, the Western Isles are fortunate not to have had a death from Covid—so the ranges would be big. My guess is that they would be so wide that there would be limited value in having an R number for different parts of Scotland. It is much better to use the data that we have on the number of cases, hospital admissions and deaths.

At this point, I need to thank all my statistical colleagues who have stepped up and started producing information much more regularly. We now publish daily figures on a whole range of statistics, including by health board. That is the place to start when examining what is going on around Scotland.

Monica Lennon: It sounds as though lots of data are available but there is still a degree of uncertainty, as you said. I understand your point about looking at a range rather than a definitive R number.

Would putting more of that information into the public domain be of benefit, in enabling people to understand how the virus is behaving in their communities? Could that help with compliance with and tolerance of the rules? Could it also give the public more opportunity to make judgments about their behaviours and health, such as choosing to be outdoors more, since the risk appears to be lower outdoors than it is in indoor spaces?

Professor Halliday: My starting point is that we have published quite a lot of that information. We have published data and quite a bit of the scientific evidence that the—*[Inaudible.]*

With regard to publishing very local data, the challenge is that—thankfully—we now have small numbers of cases, new hospital admissions and deaths. When we drill down to the numbers within a health board or a local authority area—into very small areas—the numbers are very small. That presents a challenge in terms of privacy and the presentation of that data. We are currently examining how best to go about that.

Monica Lennon: Thank you.

There has been a lot of discussion about the 2m rule. We raised that with Cabinet Secretary for the Constitution, Europe and External Affairs Mike Russell last week. The practical difficulties for workers and employers of maintaining a distance of 2m have been raised, and in the past couple of days there has been a lot of media coverage of what happens in other countries and the current thinking in Scotland and the UK.

In the science and data from around the world that you have access to, is there no consensus on whether the rule should be 2m or 1m? I do not have a list of the countries in front of me but I know that many are looking at 1.4 or 1.5m. Why are we sticking to 2m in Scotland?

Given the different harms that we need to take account of, not just to health but to the economy and people's jobs, perhaps Dr Smith will advise on why we feel that it is best to stick to a more cautious 2m, when a lot of businesses are saying that they could be in big trouble and there could be thousands of job losses in Scotland, for example in hospitality and tourism, because people cannot manage to maintain a distance of 2m.

Dr Smith: Thank you for your question. It is important that we address the risk that is associated with distancing but also acknowledge that different types of harm have arisen as a result of the Covid-19 pandemic across the world. Primarily we have been focused—quite rightly—on making sure that we reduce the health harms that are associated with Covid-19, but we have to acknowledge that there are wider harms to society and the economy as a consequence of the pandemic. We do not take any of those consequences lightly when we provide advice.

My role is to provide the public health and clinical advice that helps to shape our response. That advice is on why we should take a particular measure or approach to reduce the potential for the outbreak to harm health, more than any other aspect.

With regard to the 2m rule, you are right that a variety of approaches are being taken around the world. The World Health Organization recommends a distance of at least 1m. There is huge variation in the way in which that is applied across the world. One reason for that variation is that there is not a simple equation to calculate the risk that is associated with a distance. For instance, the smaller the distance is between people, the less time that they are able to spend within that distance before the risk of contracting Covid-19 becomes much greater.

In assessing the risk, the advisory structures across the UK have considered the different elements that are at play, including the physical distance between people, the time that people are likely to spend within that distance and the type of protection that people might have in everyday scenarios. All those factors contribute to the overall assessment of risk. The closer you are to someone, the greater the risk. That is the one aspect that is incontrovertible and known. If you have physical contact with someone, the risk is much greater than if you are at a 1m distance, and if you are at a 1m distance, the risk is much greater than if you are at a 2m distance.

09:30

When those factors have been taken into account and assessed together, the advice from the UK advisory groups has been that the UK should adopt the 2m distance rule in order to achieve the best balance in providing adequate levels of safety and reducing transmission between people. That is a balanced and sensible precaution to ensure that we reduce the risk of transmission of the virus between people. As soon as we start to reduce that distance, and the closer we get to 1m, the less time people will be able to spend at the new distance without there being the possibility of the virus being transmitted.

We must remember that the virus is highly transmissible. Given the data that we have so far, it is probably more transmissible than influenza—all the data that I have seen certainly suggests that that is the case. The virus is particularly highly transmissible because so few of us have come into contact with it. On the basis of the evidence that we have just now, my view is that, if we were to reduce the 2m distance rule at this point, there would be a much greater risk of the virus transmitting between more people.

Monica Lennon: I am looking at a list of some of the countries that apply the 1m rule, in line with the WHO advice. The list includes China, Denmark, France, Hong Kong, Lithuania and Singapore. Are they getting it wrong, or are they getting different advice?

I totally respect that your role is to advise on public health matters, but can you give us some insight into who provides advice to the First Minister on the economic impact? If businesses that simply cannot maintain the 2m distance rule, such as coffee shops, bars and restaurants, go out of business, that will have a huge impact on people's jobs and the economy, which will also lead to public health harms. In relation to the balance of harms, where does the economic advice come from?

Dr Smith: I should confine myself to commenting on the specific public health and clinical advice that is given to ministers. Obviously, ministers receive advice on other aspects of Government from other advisers. You might be aware that there is a network of chief advisers across Government, which includes the chief economic adviser, who has no doubt also been giving regular advice to ministers.

In relation to how public health and clinical advice is delivered to ministers, the advisory structure within the UK allows us to examine the evidence from around the UK and the rest of the world and to make a judgment. That is done primarily through the SAGE network, which includes a variety of sub-groups that all examine different aspects of the response to Covid-19. The primary focus of the sub-groups is the public health and clinical reasons for adopting a particular approach.

WHO recommends keeping a distance of a minimum of 1m, but its guidance acknowledges that the less space there is between people, the greater the risk. Quite rightly, we have adopted an approach that minimises the health harms to the country.

Annabelle Ewing (Cowdenbeath) (SNP): I want to pick up on that last point. I take it from what Dr Smith has said that the closer a person is to somebody, the greater the risk, and the less time they can spend so close without the risk increasing significantly. We are talking about easing the lockdown. Surely the worst thing for all of us and for our economy would be having to go into a second significant lockdown. Does that also inform the decision-making processes on the issue and many other issues?

Dr Smith: Thank you for that question, which follows on from the conversation that we have just had. One of the things that we are trying to do, and which I have tried to do from the beginning, is reduce the number of bridges of transmission, and one of the ways in which we have done that is by introducing the lockdown measures. Obviously, that has had a huge impact on society, but the measures reduce our contact with other people and therefore reduce the opportunity for the virus to pass from one person to another. That is one extreme version of the distancing that we have put in place to try to suppress the spread of the virus.

You are right to assert that the closer we come to each other, the more likely it is that the virus will spread. There is a possibility that, if we go too far and too fast and create too many bridges for the virus to begin to cross between people again as we begin to exit the current arrangement with the restrictions that are in place, we will start to see more cases developing and the R number rising, and that there will be more opportunities in our communities for the virus to spread to other people. We can clearly see how, if we did that when people are physically closer to each other, we would start to get into an area in which more restrictive measures would have to be considered again to suppress the virus.

I want to get across very carefully the point that the infection is highly transmissible. The closer people are to each other, the easier the virus will spread to other people. If we look at the patterns of spread around the country, we can see that one of the virus's key characteristics is that it is more likely to be able to spread from one person to the next where people are closer together and congregate, particularly in enclosed spaces. It is clear that we want to try to avoid that and ensure

that we reduce the chances of our having to reintroduce any more restrictive measures again in the future.

Annabelle Ewing: I have a question about the K number, which the First Minister referred to in yesterday's briefing. It would be helpful to the public if somebody explained in layman's terms what the K number is and—this is important—what significance that measurement could have in tackling the pandemic and further easing the lockdown. I direct my question to Dr Smith, but he should feel free to involve his colleagues.

Dr Smith: The K number is a real area of emerging interest. We are introducing new terms to the country's lexicon all the time. I will bring in Professor Crossman to say a little more about it.

Essentially, when we are assessing the K number, we are looking at the potential for the virus to spread to other people from a low number of people. We know from the way that infectious disease spreads that not everybody will spread it to the same extent. We know that some people do not spread the virus very easily, but there are a few people who seem to be responsible for a high degree of its spread.

That is where the K number comes in. It allows us to assess and express that transmissibility. Perhaps between 10 and 15 per cent of people are responsible for up to 80 per cent of the spread of the particular virus. We refer to "superspreading events". We know that there are particular characteristics—probably physical characteristics—of locations that make that much more likely.

We have already mentioned that the virus is much more likely to spread in enclosed spaces, where people are in close proximity to one another and where there are a lot of hard surfaces. We know that the K number is going to be optimised in those environments and that the virus will be able to spread from one person to many. Professor Crossman might want to say a little bit more about it but, in essence, it looks at the concept that a small number of people might be responsible for a great deal of transmission across communities.

Professor Crossman: The K number is another number that we can hang on to and use to measure the spread. As the CMO said, it looks at analysing clusters.

I will rewind back to an earlier point in the discussion because I think that where Scotland is in the epidemic has been slightly underemphasised. When lockdown was introduced, we were in a bad place; we were at the height of the epidemic and measures had to be put in place. Those measures have saved lives and protected the NHS, as the expression goes. They have worked and were successful.

I do not know whether you want me to say that we are in the tail of the epidemic but, because of those restrictions, we are now in a much better place. I think that we have reached the tail, because the incident numbers, deaths and other things are now trickling along. That is what happens in epidemics. However, at this point, what we do changes from managing the accelerating part of the curve, the eye-watering numbers of cases and—let us not forget—deaths to making the virus more containable.

Your question is spot-on. At this stage we try to stop a re-escalation, rebound or second wave—whatever we want to call it. However, in the context of the question, at the tail-end we mean a second wave coming from indigenous, local, remaining disease, not new introductions from abroad, or anything else. It is about what is happening in Scotland and whether infection numbers can explode again. Understanding that and managing it will be different, and that also brings in the issue of balancing the risk of that happening against other risks.

At the height of the epidemic, the model was very biomedical, or a better description would be to say that the focus was all about infection and so on, and that the economic, social and educational issues were slightly put to one side. However, as we manage the tail, those issues clearly become much more important because of how long this stage is going to go on for.

Measuring outbreaks becomes the important thing at this stage, rather than the R number. The R number will lag. In January, there were a few cases and we wondered how things were going to be. It took weeks for the signal to appear and for us to realise how the virus was going to affect Scotland and the United Kingdom. We are in that position again, and there are very few early warning signs of what is to come. It would be fair to say that examining clusters is about all that we can do, and that is why the K number is important.

09:45

The R number is the envelope for the whole of Scotland. It has to look at linked communities, which is one reason why it does not keep being reduced—there has to be a link between the people. However, we are now in a situation where the R number will be bumbling along because it indicates that we are in the tail of the epidemic. That number will not spring up quickly, but we might see clusters developing, which are measured by the variation in distribution that tells us about clustering and the outbreak of the virus.

The important message that I want to get across is that the context to the R number is where we are in the epidemic cycle, which changes the

approach—for example, when we move from lockdown to trace and protect, that changes the way in which we measure the spread of the epidemic. We would perhaps not obsess about the R number but look at other measures such as instant cases or the K number, some of which are research based. Of course, it would change the balance of the judgments that politicians have to make about the risks that Gregor Smith and others have alluded to; our science can take us only so far.

My answer is quite long, and I hope that it adds to some of the other questions.

Annabelle Ewing: Thank you. That was very interesting.

Adam Tomkins (Glasgow) (Con): How do you calibrate the health harms that are being directly caused by lockdown? What advice do you give to ministers about the appropriate balance to strike between the health harms that are caused by Covid-19 and those that are caused by the response to the virus? In particular, how do you calibrate, and what weight do you give to, the mental health and mental wellbeing harms that are being directly caused by the prolonged lockdown?

Dr Smith: That is a really good question, because the balance between those different harms is constantly on our minds. There are four main harms that we would want to consider in this context: the direct and indirect health harms that you have alluded to, and the harms to society and the economy, which may have an indirect impact on health as well. We have to take all those elements into account when we are faced with how we present advice to ministers on our approach.

We have known that the most pressing harm has clearly been the harm that is caused by the virus, particularly during March and the early part of April, when it was very clear that the potential for the virus to cause marked and serious illness and many deaths, as we have already said, was very present—that was the obvious harm that we had to address, and quickly. That necessitated the extreme actions that were put into effect, but of course, the longer those extreme actions are in place, the more likely it is that harms will begin to mount from other sources. We have been keeping a fairly close eye on the harms that are caused by non-direct health consequences, particularly on some NHS services—which we have perhaps taken for granted—being paused to allow the overall response to the virus.

I was struck very early on by the population's response to the virus. Although emergency and urgent services were still in place within the NHS, the early data that caused me concern was that perhaps people were not presenting with urgent conditions in the way that we would expect them to. There was a fall-off in emergency department attendances and in attendance at general practices for some potentially serious health conditions, including symptoms that we would normally associate with cancer, heart attacks and stroke. It became clear that there was a rising risk that people could suffer serious harm as a result. We monitor that over time, using both the NHS management data to which we have access and some of the outcome data on deaths. You will no doubt have noted our campaigns to ensure that people were still using the NHS in that way.

We must also turn our attention to the less obvious harms that people experience, particularly the emotional distress and the effects on people's mental health. That is why we have put in place many different avenues for people to seek help. We recognise that, for some people in particular, being isolated and living under the lockdown restrictions is an incredible burden for them to bear. A range of new services are being put in place to support people like that, and I suspect that we will need those services in place for some time afterwards to deal with the recovery period, as we start to come out of this immediate response.

There is another aspect to which we need to pay close attention if the country suffers longer-term economic harm as a consequence of the response, which seems likely. The picture that is emerging globally is that that is what countries will experience. Such times are often when health inequalities are widened. We know that Covid-19 has already had a significant impact on people experiencing health inequalities. That might be accentuated and amplified in the future. Teams of public health consultants are examining that closely so that they can offer guidance and advice as to the potential harms that we need to try and mitigate in that respect.

Adam Tomkins: That is helpful, and I am grateful for that, but I want to drill down in a little more detail. A number of us are increasingly concerned that our reaction to Covid is disproportionate, that lockdown is going on for too long and that we are being too slow in coming out of it. This is revealed in much of the language that you have used today. In the evaluation as to what it is safe to do, the dice are being loaded—inadvertently, perhaps.

In response to an earlier question, you said that we must reduce Covid health harms and we have to acknowledge other health harms. Why is that? Why do we not have to reduce other health harms as well as reducing Covid health harms? Why is it good enough just to acknowledge that there are other harms going on?

Perhaps it is best to talk about this not in the general but in the particular. Let us go back to the particular point about 2m versus 1m. We know that hundreds—perhaps thousands—of hospitality businesses will not be able to make ends meet if their customers have to be separated by 2m, but they will be able to make ends meet if their customers have to be separated by only 1m.

We know, as you have just said, that significant unemployment causes significant health harms. Unemployment is not only an economic problem; it is a health problem. How do you calibrate that in the advice that you are giving to ministers, and what weight do you put on the on-going mental health harms that are being directly caused by a very severe lockdown and a very slow escape from that lockdown?

Dr Smith: The first step in identifying and being able to address any potential risk or any harm is to acknowledge it. Once we have acknowledged it, we are then able to introduce things that try to mitigate the risk of the harm taking place. It is very real that the closer people are together, the more likely it is that the virus will transmit. Therefore, the evidence suggests clearly to us that the way to mitigate that risk is to ensure that distancing is appropriate to reduce the risk to acceptable levels.

In the same way, we assess the harm potential from other things, whether that be non-attendance at emergency departments or potential societal harms, and mitigation strategies are developed to try to reduce the risk of those harms occurring. In giving the advice, there is a fine balancing act in relation to the cumulative risks that society faces from the variety of harms that Covid can cause. I accept your point that the advice needs to be balanced, but I assure you that all those things are taken into consideration and assessed in the round so that balanced advice can be given to ministers. The advice is not just from me as a clinical and public health adviser but from the range of advisers that are in place across Scotland to ensure that ministers hear and consider their perspectives as well.

The Convener: We have had some very detailed answers, which is important, as there is a lot of detail that we want to hear, but we are a little behind the clock. Slightly shorter answers from the witnesses would be helpful, to allow all members to ask the questions that they want to ask.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I want to ask about the shielded group. The management of the pandemic and the science have led us to relax the lockdown for most of the population but not for the shielded group. Just the other day, it was announced that the lockdown for that group will be extended to 31 July. How can the science allow us to ease the lockdown for one group of the population but not for the shielded group? Is the science doing different things at the same time?

Dr Smith: That is an important question, because the shielded group has borne some of the heaviest burdens of the restrictions that have been in place. The burdens have been not just physical but emotional and mental. It is important that people in that group know that they are not forgotten about and that the science is still working to try to ensure that we change the restrictions that they are experiencing as soon as we can safely do so.

The key point is that it needs to be done safely. When we look at the infectious pool in Scotland as it has been, as it is now and in the models of how that projects forward, a fine assessment needs to be made for the most vulnerable people in our communities before we say to them that it is safe to start to go outside again. Those decisions are not taken lightly. Fortunately, we have widespread networks of clinical advisers who can advise us on those matters. For instance, in relation to shielding, our clinical guidance cell has been offering us advice and guidance on how we manage the extreme vulnerabilities of some in that group with the prevailing epidemiology and mix of cases that we see across communities.

At the moment, given the current infectious pool that we have across Scotland, the models suggest that by 18 June we will have got to a stage at which we can recommend that those people can start to go outside again. We know that the outdoors environment is much safer than indoors as far as transmission is concerned. It will perhaps not be safe enough just yet to say that those people can start to meet others with proper social distancing, but we will keep that under review. I expect that, over the course of July, we will be able to make further recommendations, as the wider illness pool starts to shrink.

The other important aspect is the changes that we have made over the past two to three weeks. As Professor Halliday said, we need to make sure that we have assessed those changes and that they have not had the unintended effect of causing case numbers to grow again, because it would be reckless to recommend to our most vulnerable people in society that they start going outside again if we have a rising number of cases.

10:00

Willie Coffey: Do you envisage dedicated time slots for our shielded community, to allow them to access country paths and walkways and so on at particular times of the day? That is being done in Ireland and local communities are respecting that; to know that they can get out safely and walk in the countryside and that they are protected in

doing so has been a great boost for shielded communities. Is that something that we could do in Scotland?

Dr Smith: We are working with groups across the UK to give much more tailored advice to people who are shielding, so that they can assess risk in a way that meets their approach to risk. It is tailored advice that allows them to make a judgment about the prevailing circumstances in their neighbourhood and how to go about their everyday lives. That individual information can allow people to assess their own risk, which will become important in allowing people who are shielding much more freedom of movement and the ability to make decisions with the agency that they need to regain.

Ross Greer (West Scotland) (Green): My question is primarily for Dr Smith. I am interested in asymptomatic individuals and, for the purposes of the question, I am including in that people who are presymptomatic. A study of the outbreak on the Diamond Princess, the cruise liner, found that half the passengers who tested positive on the ship were asymptomatic at the point at which they were tested. Last week, a review was published of 16 groups of Covid patients around the world that found that at least 30 per cent and more likely up to 45 per cent of cases could be traced back to people who had spread the virus without ever knowing that they were infected.

Asymptomatic transmission is increasingly being described by scientists as the Achilles' heel of current strategies across the world to suppress the virus. An Imperial College London study said that routine testing could reduce infections by up to a third.

In Scotland, around 900 patients and 900 staff appear to have caught the disease in Scottish hospitals. If we had been routinely testing NHS staff, including those who were asymptomatic and presymptomatic, how many of the deaths that are potentially associated with those in-hospital transmissions could have been prevented?

Dr Smith: That is an area of huge scientific debate just now and I will perhaps bring Professor Crossman into the discussion. Scientific opinion is still very divided on asymptomatic and paucisymptomatic spread. On balance, evidence is accumulating that there is a period, perhaps 24 to 48 hours before people become symptomatic, during which there is the potential for spread. The majority of asymptomatic people will be asymptomatic carriers without shedding virus, or so it seems. At the beginning of this week, the WHO restated its view that asymptomatic spread is a rare event. That emphasises the uncertainty that still exists in the area.

My view is that there is the potential for spread. Evidence is accumulating that, in the immediately presymptomatic period, people might begin to shed virus to an extent that makes transmissibility far more likely. Professor Crossman might want to come in on the science that sits behind that.

That is why we have built in more and more elements that look at how testing on a asymptomatic basis might contribute to the overall response to the pandemic, such as the testing of care home workers who are asymptomatic, to see whether that reveals any people who should be given specific advice about how to proceed with their work or about whether they should exclude themselves.

Professor Crossman might want to come in on the science, which seems currently to be split on the case for asymptomatic spread.

Professor Crossman: That is a topical question. It might sound slightly pedantic, but there is a distinction to be made. Some people will remain asymptomatic throughout. They will be identified only by an antibody test and will say, "Golly, I didn't know I'd been ill." They are asymptomatic cases. That is what the WHO was referring to. The accumulating data support WHO's position that those people are not super-spreaders. They probably do not shed much virus. It might be an overstatement to say that we should not worry about them, but they are different.

In the context of your question, Mr Greer, we are talking about whether somebody who does not think that they are unwell but is about to become unwell is identifiable through testing, so that other people can be protected. That is the issue. Do you test people who are asymptomatic? Why are you doing that? There is nothing that you can do for the individual; it is about protecting others. If they work in a hospital or care home, or if they live with an elderly or certainly a shielded individual, you could make that case. That is the case for testing asymptomatic people.

You referred to the Diamond Princess, which is interesting and takes me back to my original point. That was early in the epidemic, when it was exploding. If I remember rightly, about 60 per cent of the people on the Diamond Princess swabbed positive. If we went into an asymptomatic group—or into an asymptomatic ship if there was one now—that number would be in very low single figures. When we get to very low numbers of cases, there are issues about the utility and fidelity of the test and whether it is giving incorrect positives and negatives.

The balance of the judgment about whether we test asymptomatic people changes according to where we are in the epidemic curve. It is a fine choice. If you were to do asymptomatic testing, my

advice—having read the literature and talked to a lot of people about it—is that you would test according to who those people would be a risk to. If you identify those who are maximally at risk, you can build a case for asymptomatic testing.

That raises the question of how often you repeat the test. There are real complexities to that. There is no agreed number for that and there is no science about whether it should be done once a day, once a week or once a fortnight. How often you go on repeating the test becomes a matter of opinion.

Ross Greer: That is useful.

You make the point that, when we talk about asymptomatic testing, we must consider who individuals are a risk to. That brings us back to the question of whether we should routinely test healthcare staff. I accept Dr Smith's point around the uncertainty in that regard, because the evidence basis is still growing, but that suggests that we should adopt the precautionary principle. A body of evidence suggests that routine testing can reduce infection and transmission by up to a third. We are routinely testing care workers, who care for our vulnerable population, as do healthcare workers.

Dr Smith, according to the minutes of the Scottish Government Covid-19 advisory group's meeting on 7 May, the group discussed "asymptomatic healthcare workers" and asymptomatic transmission. By that point, the first nosocomial review group meeting had taken place. Are members of the Scottish Government's advisory group recommending routine testing of healthcare staff?

Dr Smith: The nosocomial review group, which is a sub-group of the advisory group, is considering that matter. Members are still examining all the associated evidence, but the group is due to bring forward advice, which we expect to be with ministers over the coming weeks.

Ross Greer: Thank you.

Confusion has been caused by the fact that the Government has adopted a policy of routine testing for care staff but has not yet taken a position on routine testing of healthcare staff. Why is there a difference between those two groups? Why was it possible to make a policy decision on care staff when a decision has still not been made—and evidence is still being considered—on healthcare staff?

Dr Smith: The decision on care workers was made on the basis of consideration from the SAGE structure and its nosocomial and care homes groups.

Ross Greer: Thank you.

Beatrice Wishart (Shetland Islands) (LD): We have touched on the sacrifice that the general population has made with regard to the lockdown and its harmful effects on individuals and the economy. Some people, such as people with hip and knee problems, are living in pain because planned operations and procedures have not been able to go ahead. Yesterday, the Cabinet Secretary for Health and Sport said that she was waiting for recommendations about further measures. What further safety measures need to be put in place to get those routine operations under way again?

Dr Smith: A variety of things need to be in place to make sure that it is safe to begin those routine procedures. Some of those relate to making sure that the immediate environment is optimised and infection prevention and control measures are in place. Before they come into hospital for treatments or surgery, we must assess patients to make sure that they are free of disease, so that they do not develop disease while they are in hospital or bring further disease into the hospital. A variety of things need to be put into place to make sure that the new care pathways for routine work are as safe as possible, so that they do not lead to unintended spread of Covid to patients or other individuals with whom people might be in contact in hospital. That work is under way across Scotland; the health boards have submitted their remobilisation plans, which are being taken forward.

Beatrice Wishart: Thank you for your answer. I will change tack a bit to ask about the possibility that a second wave of the virus will hit us—I think that the word "explosion" was used earlier about possible outbreaks. If we got to the stage of having an outbreak in an area, would localised reinforcement of the lockdown restrictions that are in place be considered?

10:15

Dr Smith: We are looking to develop as much data as possible to inform decision making. Decisions will largely be taken at a national level, but with regard to outbreak management, some less consequential decision making might be taken at local level. For example, later in the year, if all the schools are back and an outbreak is centred on a school, local decisions might be taken to deal with it, for example by excluding pupils from the school while the outbreak is managed. Other decisions should remain at national level, in the context of our overall approach.

We are trying to develop the surveillance data to allow a much more informed view of what is happening across the country, recognising that sometimes—particularly with outbreaks—the

situation will not be homogeneous across the country.

Shona Robison (Dundee City East) (SNP): The Cabinet Secretary for Health and Sport wrote to the committee this week about the Health Protection (Coronavirus) (International Travel) (Scotland) Regulations 2020, which came into force on Monday. The regulations take a four-nation approach, requiring people to self-isolate for 14 days, but Governments were under pressure to relax the regulations even before they came into force. How will the evidence be gathered to inform decisions on the quarantine measures? Will that involve SAGE, or will we also look at the Scottish context for the measures? The question is for Dr Smith or Professor Crossman.

Dr Smith: I will make a start, and Professor Crossman can then come in. When any change is introduced to a system, we need to be able to assess it to see whether it has its intended impact. That means looking at major measurements that are associated with the change.

With regard to the quarantine of travellers who have come into the UK, we need to consider the existing pool of infection in the UK, our R number and the likelihood of any traveller importing the infection into the UK, which will vary depending on where in the rest of the world they have come from.

Over time, as the global picture changes, we might find that the approach needs to change as we consider the evidence that comes through. The experience of many countries across the world—when the number of infections has reduced as they controlled their domestic epidemic of cases and moved to more sporadic outbreaks—has been that travellers can sometimes be responsible for importing those events. For instance, our Covid experience in Scotland shows that, at the beginning, multiple importations, mainly from continental Europe, introduced the disease at well over 100 points across Scotland.

As our numbers start to reduce, if countries have higher levels of transmission and a higher number of cases than we have, our risks will become greater at that time. We will take all those things into account, and advisory structures, primarily SAGE and our structures in Scotland, will look at the Scottish experience in the Scottish context and provide advice to ministers.

Professor Crossman: I absolutely agree with that. It comes back to what I said earlier about whether a rebound comes from our own population or new introductions. The issue around border controls, quarantine and so on is about dealing with new introductions.

How do we measure that? One thing that will be increasingly important is the forensic analysis of viral introductions, which can be done by measuring the genetic footprint of the individual virus—so-called viral genome sequencing. There are minor variations in the virus from around the world and we can fingerprint those. There is a scientific method that will be able to say whether a new case has been introduced from abroad, which will be very helpful for us in making policy around foreign travel and how it is managed, which is one of the most difficult issues.

Shona Robison: Dr Smith referred to international evidence. I would like to hear more about how we will gather and learn from that. The BBC—I think—referred this week to the case of a flight from Doha to Athens. The Greek Government is obviously trying to reopen flights for its tourism industry. All 99 passengers on that flight tested negative for Covid-19 in Doha, but when they arrived in Athens and were retested, 12 tested positive. I found that rather alarming. Will you and SAGE be looking at that international evidence? How will you manage that process? It would presumably be impractical to test everybody at both ends of every flight, but that example shows what the risk is. What advice would you give?

Dr Smith: I do not know the particular example that Ms Robison has described, but it perfectly demonstrates that testing is not a panacea in controlling the spread of this virus. It is helpful and we should use it, but we must understand its limitations. It is very dependent on the test being carried out in the proper way and at the time when a person begins to shed virus. The example demonstrates that testing sometimes gives false reassurance, which is something that we must always guard against.

What we will be looking for in international evidence is approaches that other countries are adopting for border controls, how they are managing the influx of people and, particularly once they get to very low levels of transmission within countries, what approach works to reduce the number of external introductions of the virus into their populations from alternative sources. Isolation is clearly one of the key mechanisms by which that can be done—transition by anyone from one place to another should be associated with isolation, because of the incubation period—but it is only one of many ways to try to manage the virus. You are right that we will use structures such as SAGE to glean that evidence from other countries and see what can be applied across the UK.

Shona Robison: Finally, is consideration being given to establishing a Scottish SAGE or do you feel that the structures that it has, including advisory structures, are adequate for the task of looking at all the issues, such as international

travel and quarantine, from the Scottish perspective?

Dr Smith: The SAGE structures offer us a huge well of expertise, drawn from all four nations of the UK. It is not just the SAGE group itself but the multiple sub-groups of SAGE that are important, whether we are talking about the new and emerging respiratory virus threats advisory group, NERVTAG, or the scientific pandemic influenza groups on modelling and on behaviours, Spi-M and Spi-B. There are also the nosocomial and care homes groups. All are important powerhouses in developing or considering the evidence that is emerging in relation to Covid-19.

It has been important for Scotland to take that information and contextualise it for Scotland. Our Scottish scientists use their own evidence and evidence that is emerging from those other structures and apply it as necessary to the unique Scottish context and population, so that we can continually check and ensure that the evidence is as relevant here in Scotland as it is in the other nations. I do not envisage that we will go to a formal SAGE structure in Scotland in the future, but we must retain our ability to use Scottish expertise and advisers in a way that allows us to make the best decisions for the Scottish context.

The Convener: I thank our two witnesses for their evidence, which has been very helpful; you provided a lot of detail. We appreciate your time, particularly at this busy period.

10:26

Meeting suspended.

10:32

On resuming—

The Convener: Welcome back. We continue our evidence taking on options for easing the coronavirus lockdown restrictions. I am pleased to welcome our second panel of witnesses: Dr Donald Macaskill, who is chief executive of Scottish Care; and Susie Fitton, who is the policy officer at Inclusion Scotland.

I remind members that, when they ask a question, they should indicate which witness the question is addressed to. If our witnesses, when they are asked a question, pause and take a breath before they answer, it will allow broadcasting enough time to turn the microphone on so that we do not miss the first few words of their response.

I want to start by putting a question to Susie Fitton. In your written submission, you mention that the First Minister said:

> "During Phase 1, some key public services—for example some respite care, children's hearings and some key health programmes—will also begin to restart their work".

However, you say that

> "no details have yet been given as to when or how these services will restart or what services will be prioritised."

Which services do you want to be prioritised and why? On what timescale would you like those services to restart?

Susie Fitton (Inclusion Scotland): There are services that disabled people rely on to support our daily living. Social care support is a key service that many disabled people rely on to lead full and participative lives. We know that many disabled people have had their social care support at home stopped or reduced as a result of the response to Covid-19.

Throughout April, we surveyed 822 disabled people across Scotland about the impact of Covid-19 and the anti-virus responses to it. That research—which I will speak about in more detail today—uncovered the fact that almost 30 per cent of respondents had had their care and support removed, which had left those in certain situations bed bound and unable to wash or feed themselves or go to the toilet without assistance from family members, many of whom had not received the necessary training or support.

In addition, the research uncovered a mental health crisis for disabled people, in particular those who could not access mental health or social care support services or respite support for carers or other individuals. Fifteen people told us directly that, as a result of a reduction in or removal of social care support, the lockdown restrictions and fear of the virus had left them suicidal and feeling that they had been abandoned by statutory services.

I personally analysed that section of the survey, and I read the comments. Single parents of two or more disabled children, where those children had previously been receiving two-to-one support, were trying to cope with holding down full-time work and supporting their children in housing situations without a garden. Disabled people who had pre-existing mental health problems that were triggered by anxiety and isolation and who were shielding were not getting the mental health support that they needed, and they were stating very clearly that they wanted to end their life.

I found those comments deeply affecting, and they brought home to me very clearly the impact on individuals of service closures and cuts to social care provision. Literally hundreds of disabled people told us that they were being pushed to the brink in terms of their mental health. That was particularly significant for disabled people who had lived experience of mental illness

that was made worse by isolation and anxiety about the future, and by the cancellation of their medical and therapeutic appointments.

A very large cohort of disabled people who are at high risk of the virus did not get a shielding letter. They have struggled to access everyday essentials such as food and medicine, and they are obviously very anxious about the resumption of services, which the convener mentioned. Disabled people who live alone and who have limited social networks or find digital or remote communication difficult or impossible find it very difficult to access online mental health support. Parents of young or adult children who have additional support needs report very stressful experiences of being in lockdown at home. That will have eased somewhat with the move into phase 1, but it will still be the case for those who are shielding or who are at high risk from the virus.

Many of those parents of young or adult children are very keen that day services should resume, in a safe way, for disabled children. They are also very keen to emphasise the need for tailored support for parents who are caring for children with additional support needs at home, where those children will not be able to go back to school when schools reopen because of the risk from the virus.

Parents say that their disabled children—in particular, those who are shielding—are at times exhibiting signs of distress, such as self-harm or violent outbursts, in lockdown because of the disruption to their lives. One single parent of two disabled children described screaming into her pillow every night because the situation at home had become so frightening and intolerable. She told us that her child was hurting herself hourly, and that there was no obvious support for her.

When it comes to the resumption of services, we see child and adolescent mental health support as being crucial. As many of the underlying mental health issues might well be with us way after lockdown, when restrictions have been eased, it is absolutely crucial that such services are funded and that the mental health support that is provided by disabled people's organisations and other third sector organisations gets the support and funding that it requires into the long term.

The Convener: Thank you for that comprehensive answer. You have touched on a range of issues, which other members of the committee will want to explore in more detail.

I would like to ask Donald Macaskill a couple of questions to help to set the scene. The Scottish Government's route map states that moving from phase 1 to phase 2 will depend on the WHO's six criteria for easing restrictions being met. One of those criteria is that

"Sufficient public health and health system capacities are in place to identify, isolate, test and treat all cases, and to trace and quarantine contacts."

In your written submission to the committee, you raise a number of concerns about the Scottish Government's test and protect approach. Will you update us on whether you think that the situation has improved since you made your submission? Do you think that it would now be safe for the Scottish Government to move to phase 2 with the test and protect system as it currently stands?

Dr Donald Macaskill (Scottish Care): [*Temporary loss of sound*.]—we see testing as being of great significance in giving the confidence that the care home sector and the home care sector need to move beyond phase 1 and into phase 2.

There have been significant improvements in the testing of care home staff, whether symptomatic or asymptomatic. The testing of residents in homes where there have been outbreaks has also improved, and I suspect that the data that comes out later today will illustrate that. However, we share the cabinet secretary's concern about the pace and consistency of that testing—in particular, the fact that the move to the ideal of one-week testing for care home staff is some distance away. Therefore, the quick answer to your question is that, at the moment, the care home sector is not confident about moving into phase 2.

There are also concerns about the practicalities of test and protect and how that might impact on the social care sector. We have been trying for some time to get a direct route into the operational element of the testing of staff. There still needs to be improvement in how the experience of social care staff—whether they are in the community or in care homes—impacts and influences the testing strategy and its operationalisation.

The Convener: Thank you, Donald. Again, other members will pursue some of those issues in more detail later on.

My second question is about allowing visitors into care homes. From the correspondence that they have had from constituents, all members will know just how distressing it is that people have relatives in care homes whom they have not been able to visit. In your submission, you say that decisions around allowing visitors

"will require to be taken at a local and individual service level, but that there requires to be national support and frameworks for establishing and clarifying when and how visits can take place which recognise the realities and experiences of all parties."

Can you explain what you want to be addressed in a national framework that will enable care

providers to develop their own local approaches to that issue?

10:45

Dr Macaskill: Scottish Care and providers have been working with clinical staff and Government to prepare guidance for visiting, and I hope that there will be an announcement on that and on the process in the very near future.

It is fair to say that there is a significant level of fear in the sector. In effect, care homes went into lockdown 14 weeks ago tomorrow. That led to a complete unreality in our care home sector. Care homes changed from being environments of enjoyment, experience and social encounter to being environments of isolation, detachment and silence. That unreality has lived on, and it has had and is having a profound impact on the psychological and physical wellbeing of some of our most vulnerable citizens.

If we take a care home that has been devastated by the virus, where the group of staff have had to say goodbye to their friends—literally—at a level and consistency that nobody should have to do, it is clear that they will be frightened of opening up their home to the possibility of that virus returning. In the case of a care home that has been fortunate in not experiencing the virus, staff there will be equally anxious about opening up to visiting.

I and others are constantly getting letters and communication from family members who are desperate to reconnect and get back in touch with their relatives. We have to balance the need for safety and virus protection against the need to restore relationships and the need to attend to the psychological health of individuals.

At times, throughout the care home response in the UK, we have erred too much towards infection control and prevention. At this stage, I think that, proportionately, we need to err and be more risky in the activities that we are prepared to permit.

The Convener: That was a very interesting response. I can understand that residents in homes who are feeling isolated are more open to the idea of the restrictions being relaxed than might have been the case a month or two months ago.

We will move on, because a large number of colleagues wish to come in and pursue some questions.

Annabelle Ewing: My first question is for Susie Fitton, and I ask it in light of the troubling evidence that she has given the committee this morning. I imagine that the committee's deliberations will be looked at by the relevant ministers, who will doubtless wish to pursue some of the matters that we are discussing.

I wish to check that my understanding is correct: this concerns a point of information. Around the second week of April, the Scottish Government announced that there would be help for people who fell outwith the shielding group, but within a number of other categories. As far as my constituency case load is concerned, I refer to those people as "vulnerable." Many constituents who have contacted me who are disabled or who fell under other subheadings of that new category obtained help with getting essential food and medicine and getting connected with other agencies. There is also the national helpline, 0800 111 4000. I would like to ensure that the people with whom Susie Fitton has been in contact are aware that help is out there and that it is on-going.

Susie Fitton: Many people made it clear to us at the beginning of April that they were struggling to get access to the food and medicine that they needed. About two thirds of those who responded on that question said that they were struggling to access shops and pharmacies. We are aware of the specific helpline for disabled people who are struggling to get access to food and medicine—and it is extremely welcome that it is in place.

As regards the at-risk group or what is deemed to be the vulnerable group, we have some concern about the use of the term "vulnerable," as opposed to "at-risk." We believe that disabled people are not inherently vulnerable, but they are made vulnerable by responses to the crisis that do not include them. We would consider that group to be at risk from the virus.

We know that the Scottish Government has announced actions that aim to address some of the issues that are causing additional stress and anxiety for that cohort of people. Most recently, the First Minister committed to not forgetting about people who are shielding in Scotland, which is extremely welcome given that that cohort includes many disabled people.

Our view is that it is not only people in the shielding group who need tailored advice. Many disabled people in the at-risk group have said to us that they are struggling to determine their risk from the virus, because they cannot find accessible and impairment-specific health-related advice. The at-risk group, who do not receive a shielding letter, also need tailored advice. What happens if those people are called back to work in the later phases of recovery and renewal but it is unsafe for them to go? They do not have evidence of their risk factor in the form of a shielding letter, so will they be able to get a fit note from their general practitioner? Will they get paid leave, or will they move on to statutory sick pay?

What happens to people in the at-risk group when the furlough scheme ends? Will their jobs remain open, or will employers seek to lay them off if they cannot return to work in a feasible timeframe? If an employer makes reasonable adjustments and makes the workplace safe, but somebody in the at-risk group—not the shielding group—believes that they are still at risk, will their contract of employment be frustrated? We urgently need specific and tailored advice for that cohort, in the same way that there is now a very welcome focus on the shielding group.

Annabelle Ewing: I undertake to draw those comments to the attention of the relevant Scottish Government ministers. I take your point, and I made reference to the at-risk group in a speech that I made in the chamber yesterday. I am sure that Inclusion Scotland will continue to work closely with the Scottish Government, as it always has done, on that point. It was well made, and I thank you for raising it.

My other question is for Dr Macaskill and looks at the issue from a slightly different perspective. I have thought for some time that the Care Inspectorate does not have the powers that it needs to deal with where we are in the 21st century, and that was quite a bit before the pandemic. In relation to both the short reach and the longer term, would matters be assisted by the Care Inspectorate's powers being beefed up in Scotland?

Dr Macaskill: [*Temporary loss of sound*.]—also comparative regulatory bodies across the UK and, indeed, continental Europe is that the Care Inspectorate has a range of powers relating to intervention, improvement and oversight that are at the highest level. The experience of many care providers in the community and, indeed, in care homes has been that, throughout this experience and unlike regulators elsewhere, the Care Inspectorate has been extremely supportive, has intervened when areas of risk and concern have been clearly identified and has been in frequent contact with practical advice and guidance. Its development of a staffing alert system in the early days of the pandemic has undoubtedly helped and prevented some of the worst excesses that we have seen, for example, in Spain and parts of France.

What might lie behind some of the concern is the degree to which in-reach health—I mean primary and secondary health—has, historically, not been as adequate in our care home sector as it needs to be. I and others have said on record for some time that there has been a failure of the whole health and social care system to recognise the significant needs of our older, and sometimes most vulnerable, population in care homes.

I do not believe that the Care Inspectorate needs enhanced powers. The emergency powers are technical. As I have communicated directly to the cabinet secretary and, indeed, in our submission to the committee, we were supportive of the emergency powers, but they were powers that lay open to the cabinet secretary and senior officials to exercise should they have wished to, regardless of the new legislation.

Annabelle Ewing: I understand the point that you are making, but it would be quite a bold person who says that a particular organisation or regulatory body does not need another look at in any respect. I would have thought that issues about registration, operational control and large group ownership—in the past, there have been failures in that the same people have been able to come along and set up another care home—would be worth looking at. Obviously, today's focus is on easing lockdown, so I will let other colleagues have their shot now.

The Convener: I remind witnesses to pause before they start answering a question, otherwise we will lose the first few words of your response. Also, we have a lot to get through, so it would be very helpful if you kept your answers as short as possible, although I appreciate that there is a lot of detail in what you want to say.

Ross Greer: I have a couple of questions for Dr Macaskill about the policy of routinely testing care staff. The number of tests that are being conducted each day suggests that that policy is not being implemented. That is no longer entirely an issue of overall capacity, because we can conduct about 15,000 tests a day. In recent days, however, 3,000 or 4,000 tests have been conducted. That includes what should be the routine testing of care home staff, anyone in the population who is symptomatic and anyone over 70 who is admitted to hospital.

Can you give a little bit more detail on what logistical barriers remain for care homes accessing the routine testing of their staff? Are there variations? Are some health boards achieving that and others not? Is the problem consistent across the country?

Dr Macaskill: We consider testing to be extremely important. On 29 April, we asked for the testing of all symptomatic residents and staff and the testing of all asymptomatic staff and residents, although that latter one has not been achieved to date. The announcements on 1 and 18 May consolidated that position.

Since then, we have seen a diverse approach across the 14 health boards. Some health boards—I could name one, but I will spare its blushes—have engaged collaboratively with care homes in their area, have completed all the tests

of residents and all the tests of asymptomatic staff in red, amber and green care homes and are routinely doing that testing each week. That shows that it can be done. However, some health boards were just submitting their activity plans yesterday. Again, I will not mention which boards those are, but the data that will be published today and in subsequent weeks will no doubt evidence where the levels of relative inability are.

We have not got it right. The care homes sector has been asking—as have the cabinet secretary and the First Minister—for us to get it right. It is one of the key tools that will enable us to address the virus and its spread in our care homes.

All this talk of recovery in the community is all very well, but those of us who are working in the care home sector are still fighting the virus, and we are not even contemplating recovery. Yesterday, I had a care home manager on the phone who was virtually in tears because she had been walking to work and everybody was getting back to normal—nobody was social distancing and nobody was wearing masks when she went to her local supermarket. It is almost as if the rest of the world is getting on with life and the care sector yet again seems to be forgotten.

We must get testing right. There are clear reasons, which we all understand, why it is not working, and it is down to the health boards to get it right.

11:00

Ross Greer: I have one follow-up question, which is about how the test, trace and isolate approach affects care homes. Obviously, if we quickly get to the point of routine testing of care home staff, that will result in more positive tests. What are the workforce implications of that? If a member of staff in a care home tests positive, the requirements of the test, trace and isolate approach suggest that, as well as that person being required to isolate, the people around them—including a significant number of staff in the care home—will be asked to isolate as well. Is the sector confident about workforce capacity? If test, trace and isolate is to get up and running effectively and quickly, that situation could happen in a number of homes in the same area in rapid succession, particularly where there is a concentration of homes in an area. Is there enough workforce flexibility to cope with that?

Dr Macaskill: Partly through the tool that has been developed by the Care Inspectorate and partly through the enhanced support from directors of nursing and public health, resilience plans are being drawn up for each care home in each health board area so that, if the testing results in a significant loss of workforce, those issues can be met. To date, even whole-home testing has not evidenced the significant and highest level of loss of workforce that might have been feared.

As we move to the test and protect phase and that issue becomes a wider one for the whole community, we must prioritise social care staff in households where a member of the family has tested positive. We must provide enhanced and focused support to enable the care home worker or home care worker to be tested as quickly as practicable so that they can return to work. We do not have clarity on the process to enable that to happen, and we are working with colleagues in health boards and the Government to ensure that the test and protect system fits in with and contributes to the overall testing of care homes and others.

Monica Lennon: My first question is for Susie Fitton—thank you for your comprehensive opening remarks and your answers so far. The survey that you mentioned is concerning. I want to pick up on issues concerning children. In your written submission, you highlight the issues for children with additional support needs, their particular needs for care and what they are missing out on when they are not at school. Will you say more about what you would like to be in the lockdown easement plans or the route map for children and young people? What are your concerns about the long-term impact on disabled children who are shielding and who have not had contact with other children and young people?

Susie Fitton: For disabled children with neurodivergent conditions such as autism and attention deficit hyperactivity disorder, disruption to routine and reduction in structured activity during the day is leading to some very difficult situations for their parents in lockdown at home. We received reports of self-harm, challenging behaviour and continuous meltdowns. The situation is particularly difficult for children who cannot understand social distancing or the disruption to their routine. We have found that families with young people who have communication impairments or children who find it difficult to express how they feel at this time are under particular pressure.

As we emerge from lockdown, we would like the reopening of the support services that disabled children and young people need, including the resumption of day-care provision, to be prioritised. However, I cannot stress enough that many parents of disabled children reported to us that the home care packages for their children had been reduced or stopped completely. Thirty per cent of responses to the question on social care at home came from people who had had care provision stopped or removed. I cannot stress enough the need for local authorities to reinstate the social

care support that young people receive at home and to ensure that personal protective equipment is getting to parents and families who provide care for their young person at home, in particular if that person is in the shielding group. We have seen a very welcome focus on the targeted provision of PPE to disabled people who have personal assistants to support them in the home, so I believe that there are hubs where people can access PPE. The same approach needs to be extended to families of disabled children where a child is shielding.

It is vital, when we move into the recovery and renewal phase, with schools opening in August, that we make appropriate and inclusive decisions on how disabled children who have additional support needs are supported to go back to school effectively, and on what should be done for families where their children cannot go back to school because of the risk from the virus. Many parents of young people have reported to us that home schooling is simply not an option for them for many reasons, including that they are not receiving the ASN support at home that their child previously received in school. Many parents have reported to us that they simply cannot replicate at home the kind of support that their child received in school. There is therefore a significant risk that inequalities in attainment will be exacerbated. Children in Scotland who have ASN already face a significant attainment gap in comparison with non-disabled children, so there are real issues in that regard.

We need the Scottish Government to take into account the long-term impact of lockdown on the mental health of parents of disabled children, and to acknowledge that many disabled children cannot follow social distancing rules. The Scottish Government showed a degree of flexibility in the guidance on social distancing that it issued earlier in the lockdown, in which it acknowledged the needs of young people with autism or other conditions that make it very important that they take regular exercise in wide open spaces. In the early part of the lockdown, however, parents of disabled children were reporting to us that they simply could not exercise their children, because they could take them out only in the local area and were unable to go to the parks and open spaces that the children had previously exercised in. We saw some flexibility in that regard but, as we move forward, we need an acknowledgement that some disabled children cannot follow social distancing rules.

I do not have an easy answer to that, but we need to acknowledge it. We also need to acknowledge that families of disabled children and children with additional support needs are under particular pressure because of the closure of leisure centres. Swimming is a therapeutic activity for many of these children, and also for adults. Your question was about younger disabled people, but therapeutic exercise is also extremely important for disabled adults, and particularly for those who are managing pain conditions.

As the restrictions are eased, we would like there to be prioritisation of opening, perhaps at particular times, for disabled people who need to take therapeutic exercise. Disabled people are reporting a significant increase in pain, which is impacting on mental health conditions and reactions to the crisis. We know that therapeutic exercise is extremely important for many disabled people. If there is to be a phased return of local authority provision, we would like specific attention to be paid to the opening of swimming pools for people who previously received things such as hydrotherapy or physiotherapy, which they cannot get at present. Therapeutic exercise is extremely important.

Monica Lennon: Thank you, Susie. I had a number of supplementary questions, but you have covered a lot of ground in your answers. They are on the record, and I am sure that ministers will be listening carefully.

I will move on to some questions for Dr Macaskill about Scottish care homes. The first is about sick pay for staff. A number of people have got in touch with me who are still not able to access full sick pay. Some of them have had to be off work and self-isolate, and they have experienced financial detriment. Can you update us on how many of your members offer full sick pay as a benefit? How are your discussions going with the Government about the support that it might provide to care home staff in that regard?

The Convener: Can I intervene for a second before you come in, Dr Macaskill? We need to remember that our questions should be focused on easing the lockdown restrictions. We should be careful not to stray into the territory of, for example, the Health and Sport Committee, which might want to pursue such questions. By all means answer the question, Dr Macaskill, but I ask Monica Lennon to bear in mind that we are meant to be looking at the lockdown and not at other, wider issues.

Dr Macaskill: I will respond briefly to Ms Lennon's question. We are having very constructive discussions with the trade unions, the Convention of Scottish Local Authorities and the Scottish Government, and I believe that a final settlement on the issues should be reached by COSLA leaders later this week. There have been a number of very purposeful meetings this week.

Ms Lennon and other members of the committee will know that, whether the providers are charitable, not for profit or private, the vast

majority of social care in Scotland is paid for by the state—by local authorities and the Scottish Government. The national care home contract, which keeps costs defined, does not allow providers to pay enhanced statutory sick pay. Clearly, organisations such as Scottish Care have been asking for a change to that for years, but both national and local politicians have prevented that from being operationalised.

Monica Lennon: I am grateful to Donald Macaskill for his answer. He said earlier that the crisis in care homes is far from over. We know that testing is critical to moving forward and that fear around debt has been a huge barrier to some staff accessing testing.

I have a question on the really important issue of the resumption of visits. I think that over 60 per cent of care home residents have dementia, and that issue has been raised by the general public. As regards PPE and current access, Dr Macaskill, do you see a need for a change in the current guidance such that, if people start to visit care homes again, they should wear PPE as a matter of course? I know that that is part of the route-map plan, but do we need a change in the guidance on PPE, so that everyone working in or visiting a care home has access to suitable PPE and is wearing it as much as possible?

11:15

Dr Macaskill: Every staff member should have access to PPE. We have worked closely with the Scottish Government and NHS National Services Scotland to ensure that that is the case, despite the global challenges of getting access to PPE.

As far as visiting is concerned, it will almost certainly have to take place outside, although, over a period of time, it could gradually start to take place inside the care home. Family members will almost certainly need to wear appropriate PPE, and we are working with colleagues to ensure that there is a sufficient supply of that PPE. Even that is difficult, though.

More than anything else, this is what troubles me about the past few weeks. Thousands of individuals have been locked away from their family, their friends and their community—people who used to pop in at different times of the day. Now, they are not able to see their relatives except through windows. The sooner we can restore that relationship, the better, but we have to balance that with keeping people safe.

PPE is one of the critical mechanisms to enable that to happen, and we are clear about it. Scottish Care said on 29 April that we believe that the universal wearing of masks is necessary in all care encounters. I believe and expect that we will move to that over the next period. We need to protect visitors and the wider community. Most of all, we need to protect the residents. However, protection has to include restoration of relationship.

Monica Lennon: I have a brief supplementary question. When you say “masks” are you talking about medical masks or do you mean face coverings—or a bit of both?

Dr Macaskill: It will be a bit of both, depending on the context of the person visited. If somebody is at end of life and has Covid, the person who visits will, unfortunately, have to wear fairly full PPE, including a medical mask. That has happened, and it is happening. That is challenging and difficult, but it is better than absence.

Stewart Stevenson: My question is directed initially to Dr Donald Macaskill. Before I ask it, however, I should make a couple of declarations. First, I have a very close family relative who occupies a senior position in a care home, albeit that they are currently not working there because they are shielding. Secondly, because I am over 70, I am categorised as vulnerable. I do not think that any of that matters, but it is important to make that point.

Why have so many care homes done extremely well through this situation, keeping infection beyond their doors? We have heard a lot about the problems, but we have heard rather less about the successes, and it is always good to acknowledge success wherever we can. What can we learn about those successes, and what lessons can we apply from them across the industry so that, as we reduce our lockdown measures, we take the best possible path for care homes?

Dr Macaskill: That is a complicated question, which clearly exercises the care home sector, the Cabinet Secretary for Health and Sport and the clinical group concerned with care homes. We are asking that question not just in Scotland but elsewhere.

We are getting evidence that one of the things that influences that success is the size of the care home. Many of our care homes are residential rather than nursing, and there is a different community and level of need in a residential care home compared to a nursing care home. There are some care homes where staff have, very sacrificially, moved into the care home and live there.

We also need to explore other data that has been published. For instance, 9 per cent of those who have tragically died in Scotland’s hospitals came from care homes, whereas the comparative figure in England is 27 per cent. What was happening there at different stages of the pandemic?

All of us who are involved in the care of citizens—whether as the front-line nurse, the manager of a care home or the operator of a care home—want to learn lessons in order to protect people, and we are still learning those lessons. We are absolutely convinced that the quick access to PPE that has been enabled by the Scottish Government and the early lockdown of care homes have both assisted in controlling and managing the virus. Testing is the next stage in that process, and we need to get that right.

As we move forward, all of us will reflect on whether we did what we could have done and on whether the lessons that we have now learned need to be intrinsically at the heart of any future response.

Beatrice Wishart: I am impressed with the work that Susie Fitton has done, but I am horrified at some of the information that has come out in her survey and in her answers to colleagues. The increased pressure on disabled people and their families has been highlighted. For example, 64 per cent of people indicated in the survey that they were struggling to access food and medicine. You have touched a little bit on that, but is it still the case? How might the easing of lockdown restrictions affect disabled people and their families?

Susie Fitton: I will outline the key pressures on disabled people at the moment. I have talked about the fact that social care support has been stopped or reduced, and disabled people have new or increased caring responsibilities. Since the start of the pandemic, about 40 per cent of disabled people who responded to our questions have been experiencing challenges with caring for children or family members, so there has been not only the reduction or complete removal of support but the sudden acquisition of new or increased caring responsibilities.

As you mentioned, disabled people are struggling to get access to food and medicine. As I mentioned, there has been a response to that from the Scottish Government and local authorities. We will have to follow that issue throughout the recovery and renewal phase, to see whether disabled people are still struggling to get access to the food and medicine that they need to the extent that they reported to us in April, when 64 per cent said that they were unable to access the food and medicine that they needed.

I will talk about that in slightly more detail. We found that many of the systems for supporting disabled people to access food and medicine were inaccessible. The processes that had been put in place, particularly to support access to food, were not accessible to disabled people and had been put in place without consulting disabled people. Initiatives such as vulnerable shopper lists were creating extreme anxiety for many disabled people who were at high risk but were not in the shielding group. They were unable to get themselves added to the lists, particularly in the early stages of lockdown. Many disabled people were already reliant on food deliveries to their homes because of the inaccessibility of the built environment or other impairment-related issues. They were long used to not being able to get to the shops, but they were suddenly completely unable to secure delivery slots or receive tailored support with shopping from local initiatives.

On accessing medicine, many respondents described experiencing significant delays in getting their medication, including insulin—that is very worrying—vitamin B12 injections and pain relief. The reasons given for that were that chemists were unable to dispense the medication, that appointments for medication to be administered were cancelled, that pharmacists were dispensing smaller amounts of medication and that many disabled people had significant difficulty in getting to the pharmacy. If a further lockdown was initiated because of a second or even third wave of the virus infection and sufficient measures were not in place to ensure disabled people's access to food and vital medicine, a further, potentially larger crisis could result.

We argue that the involvement of disabled people and their organisations in emergency planning is vital to ensure that we do not see any further issues with access to food and medicine for disabled people. We will keep an eye on the current situation, but we know that there have been efforts to address it. We commend supermarkets for having priority shopping hours for disabled people, but we have had less positive responses from disabled people about their experiences in supermarkets. People with communication support needs and people with sensory impairment report not being able to communicate very easily with supermarket staff because of the necessity for staff to wear masks, which are a real impediment to disabled people who need to lip read, for example.

We also know that social distancing in supermarkets is particularly difficult for many disabled people. People with mobility impairments find it very difficult to queue for long periods, and people with sensory impairments find it very difficult to know where in the shop they can go unless they have a sighted guide, which proved very difficult for some disabled people when only one individual at a time was allowed in the shop. We received reports from disabled people that they received less-welcoming statements from supermarket staff in terms of supermarkets meeting their access needs.

As we emerge from the crisis, a lot of work needs to be done to ensure that there is a real improvement on the results that we reported at the beginning of April about access to food and medicine for disabled people.

Beatrice Wishart: Thank you, Susie. You have probably pre-empted my next question, which is about what would happen if there was a second wave. You have already highlighted to others that we need to reinstate social care at home and prioritise the reopening of day care services, and you have highlighted the long-term impact of the lockdown on mental health services. We urgently need to get measures in place for all that. Obviously, we hope that there will not be a second wave but, if there is one, do you think that the scenario will be different from the one in March and April?

Susie Fitton: There have been excellent responses to many of the issues that we raised because of the initial findings of our survey. I commend the Scottish Government for the clarity of its message. Perhaps the only significant omission is disabled people who are at high risk and are not classed as shielding. As I mentioned before, that cohort of disabled people is much larger than the shielding group. It includes people over 70, people over 60 with hypertension, people with diabetes and people with blood disorders. Up to an additional one million people could therefore be at risk from the virus. Those people need a similar focus, and we need to think about the advice and guidance that we give them. We need to think about the impairment-specific guidance that we give to disabled people.

11:30

Will the response be different? I think that we have learned a great deal by now. We have started to learn what works and what does not work.

We warmly welcome the very clear commitment to human rights, equality and social justice in the route map that the Scottish Government has produced as we consider options to relax the restrictions. However, we need to be clear that there can be a gap between positive policy intention and disabled people's experience on the ground. One reason why we surveyed people in the first place was to make sure that we were gathering actual experiences from disabled people.

That gap is probably most stark in relation to the provision of social care support. We saw the Cabinet Secretary for Health and Sport announce that local authorities should not be cutting back on care during the crisis and that there was a commitment to further investment in social care support and ring-fenced money to support the sector in times of crisis, but we are still hearing from disabled people who are having their packages of care removed.

It is absolutely crucial that disabled people are told when that care will be reinstated, because there is a distinct lack of trust on their part that it will ever be reinstated. I think that many committee members will be aware from their constituency work that disabled people face extreme barriers and frustration in the assessment process for social care support and in getting the support that they need. There is a lack of trust that that care will be reinstated at some point, so we would like reassurances in that regard.

Shona Robison: The question that I had for Donald Macaskill has been asked, so I will ask Susie Fitton a brief question.

In your evidence, you confirmed that those who are most at risk from the virus are also most at risk from the consequences of the lockdown. You have given a lot of evidence in this meeting on the priorities that you see for those whom you represent and are in contact with. You have also talked a fair bit about day services and support services resuming in a safe manner as the lockdown eases. That is important because, for families to have confidence in those services, they have to believe that they are safe. How much contact and consultation is there with those families on what "a safe manner" means? It seems logical to me that there would be consultation and partnership in rebuilding some of those services in a different way, in order to have the confidence of the families who use them. Are you aware of that happening?

Susie Fitton: I have been made aware that other third sector organisations are looking to consult their members on the resumption of day care services, particularly for adults with learning disability. I know that the Scottish Commission for Learning Disability is looking to involve us, as well as other stakeholders and parents and families, in that. That is my only knowledge of an effort to involve parents and families in considering how services will resume and how day centre services will resume safely.

An overarching issue and a key point for us is long-term, sustained investment in involvement: disabled people need to be involved in planning for the emergence from Covid-19. We have worked for a long time to establish models in which disabled people can be involved in policy development. For example, we have people-led policy panels that have effectively influenced the direction of adult social care reform in Scotland by working with the Scottish Government, COSLA and other partners. There is a panel of 50 disabled people with different experiences of social care

support, which includes older people. Service users have, over an extended period of time, drawn up a blueprint for adult social care reform, and we have seen experienced panels influencing the direction of travel in relation to the new social security system in Scotland.

We have therefore seen models in which the involvement of disabled people has led to the development of policy that meets their needs. That involvement is crucial. Parents of young disabled people need to be consulted in a timeframe and in an accessible way that allow them to respond, and in a way that will not increase their anxiety and fear. There will be significant anxiety about disabled young people returning to services. Many disabled people, many parents of disabled young people and many disabled parents of disabled young people are in a real catch-22 situation at the moment because the house is a pressure cooker in terms of the multiple demands that are being made on parents regarding care, home schooling, their own work commitments and managing the anxieties and stress around that. Many of them will therefore be extremely keen for day centre services to reopen. We need to find out what they consider to be safe provision, but I am not aware that there are any wholesale efforts to consult families on that.

We will certainly investigate that and come back to the committee if it would like specific information on it. However, the involvement of those families is crucial and we are very keen to assist in making sure that their views are gathered appropriately and that they influence decision making.

The Convener: Thank you. Willie Coffey will be the last questioner.

Willie Coffey: I have only one question, which is for Dr Macaskill. I presume that the testing policy will carry on for as long as it has to as we move through the different phases of easing the lockdown in care homes. I have heard from some local people about the symptoms of the virus in patients who have dementia and that behavioural changes can sometimes be an indicator of the presence of the virus in them. Are you familiar with that observation? Is there any clinical evidence to support it? Would that influence your testing policy going forward, particularly in care homes and for patients with dementia?

Dr Macaskill: The quick answer to that question is yes. This pernicious virus presents itself differently in older people who are living with dementia, and we now know that probably in excess of 85 per cent of the people in our care homes live with dementia at some stage. That is a much higher figure than we previously thought it was. We know that, in older people with dementia, the virus presents in a way that is very different from the classic symptoms that we have all grown used to—the persistent cough, the loss of taste and smell, and so on. There are mood changes in older people with dementia, but they are difficult to determine because the process of lockdown has resulted in a change of mood in individuals. People have literally turned their faces to the wall and gone into themselves. People go off their food and present differently in terms of their general health with regard to aspiration, their bowels and so on.

A lot of evidence is gathering that this pernicious virus presents differently in that most vulnerable population. That has been determined internationally, and I know that Professor Graham Ellis, who is an adviser to the chief medical officer, is doing a lot of work with the care sector so that we are better able to identify the early stages of when an individual has, unfortunately, developed the virus. That will impact on testing, and testing will remain.

An interesting thing that we need to begin to explore is the presentation of the virus in people who are living with dementia in their own homes in the community. That is the next battleground against the virus. We have a highly vulnerable population being cared for in their own homes, and we need to turn our focus increasingly to that group of individuals.

Willie Coffey: Thank you. It is important to get that message.

The Convener: That is the end of questions this morning. I thank our two witnesses for their time and for answering our questions so comprehensively. The committee's next meeting will be a week today, when another panel will give evidence on easing the lockdown restrictions.

Meeting closed at 11:41.

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