OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Committee

Wednesday 30 September 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 30 September 2020

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COVID-19 COMMITTEE
17th Meeting 2020, Session 5

CONVENER

*Donald Cameron (Highlands and Islands) (Con)

DEPUTY CONVENER

*Monica Lennon (Central Scotland) (Lab)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Maurice Corry (West Scotland) (Con)
*Annabelle Ewing (Cowdenbeath) (SNP)
*Stuart McMillan (Greenock and Inverclyde) (SNP)
*Shona Robison (Dundee City East) (SNP)
*Mark Ruskell (Mid Scotland and Fife) (Green)
*Beatrice Wishart (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Richard Foggo (Scottish Government)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Professor Jason Leitch (Scottish Government)
Willie Rennie (North East Fife) (LD)
John Swinney (Deputy First Minister and Cabinet Secretary for Education and Skills)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

Virtual Meeting

Scottish Parliament

COVID-19 Committee

Wednesday 30 September 2020

[The Convener opened the meeting at 10:00]

Interests

The Convener (Donald Cameron): Good morning, and welcome to the 17th meeting of the COVID-19 Committee. We have received apologies from Beatrice Wishart MSP, who is attending another parliamentary committee meeting. Willie Rennie MSP has joined us as a substitute.

I turn to the first item on the agenda. The Parliament agreed changes to the committee's membership on Wednesday 16 September. Stewart Stevenson and Ross Greer have moved on to take up other parliamentary roles. I put on record the committee's thanks to Stewart and Ross for their valued contribution to our work.

I welcome our new members, Stuart McMillan MSP and Mark Ruskell MSP, to the committee and I invite them to declare any registrable interests that are relevant to the committee's remit.

Stuart McMillan (Greenock and Inverclyde) (SNP): I have no relevant interests to declare, but I remind members that I am the deputy convener of the Delegated Powers and Law Reform Committee.

Mark Ruskell (Mid Scotland and Fife) (Green): I have no interests to declare.

Covid-19 Framework for Decision Making and Scotland's Route Map

10:02

The Convener: Agenda item 2 is the Covid-19 framework for decision making and Scotland's route map through and out of the crisis. Members will be aware that the First Minister announced the Scottish Government's intention to bring forward new restrictions to respond to the coronavirus on 22 September, which are now in force. We will formally consider the secondary legislation that gives effect to those restrictions at our next meeting. In the meantime, this meeting is intended to be an open session in which the committee is able to ask ministers and officials about how the latest restrictions fit into the Scottish Government's wider plan to respond to the pandemic and what lies ahead.

We are joined by the Deputy First Minister and Cabinet Secretary for Education and Skills, John Swinney MSP, and the Cabinet Secretary for Health and Sport, Jeanne Freeman MSP. The ministers are supported by Scottish Government officials Professor Jason Leitch, who is the national clinical director for the Scottish Government, and Richard Foggo, who is the director of population health for the Scottish Government.

I welcome you to the meeting and thank you for attending. I invite the Deputy First Minister to make an opening statement.

The Deputy First Minister and Cabinet Secretary for Education and Skills (John Swinney): Thank you. Over the summer, Scotland has made major progress in tackling the Covid-19 pandemic. We have progressed cautiously through the phases of the route map, taking care at every step to ensure that it was safe to proceed. At times, we have had to pause and take a little longer to make progress, but we have now reached a point in phase 3 where around 96 per cent of our businesses are trading again, although many will be operating below full capacity. Our children have returned to school and many social activities have been able to resume.

However, the virus is spreading again. The R number has been above 1 for several weeks and it may currently be as high as 1.6. We have already responded with new measures: further restrictions on social gatherings including not allowing people to meet other households in their homes and a 10 pm curfew in hospitality settings. If we need to go further, we will do so. We need to bring the R number down below 1 rapidly so that the virus

returns to a downward trajectory, and we need to suppress the virus back to very low levels again.

Our route map describes an evidence-led, transparent and phased approach to varying restrictions. In order to judge whether and when restrictions can be changed, a range of evidence is considered on the progress of the pandemic in Scotland, including what we know about the reproduction rate—the R number—of the virus and data on the number of infectious cases.

The route map is linear in the sense that it charts a course from the height of lockdown towards the new normal in phase 4, when the restrictions can be lifted. However, it has built-in flexibility to enable us to respond to the evolving challenges of the crisis.

We have used phase criteria to determine whether it is safe to proceed with further easing of restrictions, and, when the data tells us that it is not safe to do so, that allows us to pause changes, as we did at the most recent review on 10 September, and to reintroduce restrictions where those are necessary.

Since the start of the route map, we have always said that phase 3 would bring outbreaks. They come with the reopening of the economy, public services and broader society that alleviates the broader harms of the crisis. What we must now do is take effective action, guided by the evidence, to keep those outbreaks in check. We are making changes at a pace and level that we think is right and safe for our current circumstances in Scotland. The deteriorating status of the epidemic means that decisions need to be taken quickly when intervention is required to suppress the virus again in Scotland. Other countries in the United Kingdom and across the world are grappling with a similar situation. That is why we have already put in place further measures across Scotland to tighten our restrictions on social gatherings. Those are necessary to prevent the spread of the virus from one household to another. In doing so, we are seeking both to suppress the virus to very low levels and to protect people's jobs and livelihoods, while enabling our children to go to school and key public services to continue. That is consistent with our four-harms approach, which involves suppressing the virus first and then seeking to minimise the broader harms caused by the crisis.

On Sunday, we published guidance that explains how the current restrictions on social gatherings apply to students living away from home. That guidance applies from Monday 28 September and should be read by students alongside wider Scottish Government guidance, as well as any local restrictions that are in place in their area.

Our principal defence against the virus remains human behaviour. Physical distancing, following the FACTS guidance—that people should wear a face covering, avoid crowded places, clean hands and surfaces regularly, stay 2m away from other people and self-isolate and book a test if they have Covid-19 symptoms—and measures such as test and protect, along with other wider mitigations, can help, but they must be deployed to maximum effect, and, ultimately, it is what we all do that matters most.

The Convener: I invite the Cabinet Secretary for Health and Sport, Jeane Freeman, to make an opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Good morning. I am grateful for the opportunity to be with you this morning. I know that you are all acutely aware that we are now six months into this country's response to the coronavirus pandemic. We have asked a very great deal of people who live in Scotland, requiring them to follow measures that deviate from previous habits and change their way of life, and I cannot repeat often enough my heartfelt thanks to people in Scotland who have helped to reduce the spread of the virus and have saved lives as a consequence. However, as we move into autumn, we are seeing an upsurge in cases of transmission—as the Deputy First Minister has just said, the R number is our indicator of spread—providing us with a very short timeframe in which to take action.

As you have heard—and as you said, convener—on 22 September, the First Minister announced a new set of restrictions to protect the population from the spread of Covid-19. There have been difficult decisions to make throughout the response to the pandemic, and the decisions on 22 September were no different. We see the new measures as necessary actions to prevent a resurgence in community transmission of the virus and remove the potential for a rapid return to the pressures that we experienced early in the year. As you know, the new measures focus on there being no household visits and a 10 pm closing time for hospitality.

As in every decision, many factors are at play. Our response to the pandemic is informed by clinical and public health advice, which ensures that the health of the population takes priority. However, we are conscious of the harm that lockdown can do to the economy—in particular, to the hospitality industry and, importantly, to the mental wellbeing of the wider population. That is why, as we make decisions, we try, as far as we can, to balance the protection of life and the care of those who are most at risk from harm from the virus with fairness and quality of life.

On the basis of the analysis by Public Health Scotland and the chief statistician, we took a decision at a pivotal point in the upsurge of transmission to reintroduce those measures. We also looked beyond Scotland's borders when modelling our work and taking on evidence. A review of international experience, following the first wave, showed us that countries that implemented non-pharmaceutical interventions earlier had lower levels of hospitalisations and deaths than those that delayed.

The shape of the epidemic curve in Scotland has followed a similar trajectory to that in France, with a lag of about four weeks. France is now experiencing an increase in hospital and intensive care unit admissions—a position that we want to avoid as far as we can. On that basis, the package of further measures to reduce transmission was introduced as an early intervention. As the Deputy First Minister has said in relation to the four-harms approach, those measures are given careful and close consideration. They are undertaken in collaboration with the chief medical officer's advisory group, informed by contributions from the Covid-19 national incident management team, the Covid strategic insights group and our Government's senior clinical and policy leads.

Our previous experience of the virus has shown that it can spread quickly from one person to a much larger number of people over a very short period of time. That is why we took the decision to apply the restrictions at a national level rather than take a regionalised approach. For communities and local authorities in Scotland's Highlands and Islands, that decision was understandably met with questions. I understand their frustration with the approach and their desire to protect local businesses. However, despite their natural barrier to transmission, there have still been cases of infections in those island communities following the initial lockdown that we had earlier in the year. Special exceptions based on geographical location would need to come with and be balanced by travel restrictions, in this instance, to and from the islands. The health risks and the challenges posed to the economy and local businesses in those communities were carefully considered and, on balance, we decided to implement national measures applicable to every part of Scotland.

As the Cabinet Secretary for Health and Sport, my priority is to protect and improve the health and wellbeing of the people of Scotland. Supported by clinical advice, I believe that these new measures enable us to do that in a collective effort as we continue to deal with the pandemic.

I am grateful for the opportunity to make those short opening remarks, and, as always, I am happy to answer questions.

The Convener: I will ask the first question. The committee frequently debates the importance of public consent or buy-in to public health measures imposed by Government. Last weekend, when it came to the rules relating to students, we saw that there is a need for clarity and consistency and for as much notice as possible to be given, because, without that, it is difficult to achieve buy-in.

With that in mind, and looking to the future, I want to ask about two events that are coming up. There has been quite a lot of speculation about a mid-October circuit-breaker lockdown. Is that likely to happen? If so, what form will it take, and when will we know the details? Perhaps both the Deputy First Minister and the health secretary could answer that question.

John Swinney: The Government looks carefully several times a day at the progress of the epidemic nationally and in individual parts of the country, so we are constantly considering whether there is a need for us to take more or less action, depending on the prevalence of the pandemic. All these issues are kept under review and, as the health secretary and I have both made clear, we take decisions on the basis of the evidence that is put in front of us about the prevalence of the pandemic and a multiplicity of advice from a clinical perspective and the wider policy perspective. We need to consider all of that when coming to decisions.

10:15

Some form of circuit breaker in October has been suggested in the advice that has emerged from SAGE—the scientific advisory group for emergencies. I would not say that that is a specific proposition; it is more the raising of the possibility that, if the pandemic continues to grow at an accelerating rate, there might be the necessity to take some form of interruptive action to try to slow further and more aggressively its development. However, no decisions have been taken for that to be the case. The suggestion has been made, and the elements and circumstances are being explored. It will depend on two fundamental elements being made more certain: whether such an interruptive action is necessary and detailed work on what that might involve, which is being considered. I stress that no decisions to that effect have been taken, but the purpose of that would be to make a more aggressive interruption in the development of the pandemic if that were judged to be necessary closer to the time.

Jeane Freeman: [*Inaudible*.]—in relation to the other part of the convener's question in addition to what the Deputy First Minister has said. On how we consider whether we need to take additional actions, members will know that there is always a time lag between implementing or releasing levels

of restriction and seeing the impact of that and whether that has produced the effect that we were looking for—we are talking about the restrictions that were introduced on 22 September in this instance. We are looking to bring down the R number and to continue our overall strategy of suppressing the virus so that it is as low as possible.

We are only a week in, and I know that our not giving definitive answers at this point can feel frustrating, but we are not doing so because we rightly need to see what impact the measures are having on our overall objective of reducing the infections pool and the R number in the Scottish population.

On the convener's correct point about compliance, compliance rests on trust—on people trusting what we say and the basis on which we say it, and trusting that we are saying it clearly. We conduct consistent checks with the public on how well they understand what we are saying, how well they are implementing that, and what their level of implementation is. I am pleased to say that the level of trust in the Scottish Government and our clinical advisers has remained consistently very high over the period. If we see that groups of the population may not be understanding exactly what we are asking them to do as clearly as we need them to or are not implementing all the measures to the degree that we want them to, we can modify our public information campaigns in order to target where there may be gaps. We do that persistently.

As we learn more about the virus over time, we learn more about how to keep the public informed and how to keep them with us. In that regard, we are particularly aided by Professor Stephen Reicher, who is, as members know, from the University of St Andrews and a member of our chief medical officer's advisory group.

The Convener: The other event that I want to ask about is Christmas, which is three months away. I entirely accept that we do not at this point know where we will be in respect of transmission and the R number then but, given that students will be returning home after term time, what planning for that is happening? Can you reassure the committee that the Government has that firmly in view?

John Swinney: The Government has that issue firmly in view. Christmas is an incredibly special time for families the length and breadth of the country, and we want to minimise any impact on the ability of individuals and families to gather together around that time. However, we are, of course, living in very unusual times, given the extent of the pandemic and the threat that it poses to the population.

We have gone through a process of supporting students as they embark on the academic year. A large number of students have moved into student accommodation and there are some challenging outbreaks in various parts of the country; those are being managed and support is being provided to students. The Minister for Further Education, Higher Education and Science, Richard Lochhead, will make a statement to Parliament this afternoon to set out further detail on those steps.

A crucial part of our thinking is about how we ensure that students are able to be with their families over Christmas, if that is their wish, as they normally would be. A central feature of the steps that we are taking with universities will be to ensure that students can participate in the Christmas break in the fashion in which they would ordinarily want and be able to do.

We heard some thinking on that question from the United Kingdom Government yesterday, and we are working closely with the UK Government on many aspects of these questions.

The Convener: My final question is health related. I would be grateful to have a view from the health secretary, and from Jason Leitch if possible, on household transmission.

I think that I am right in saying that restrictions have been in place in the west of Scotland for several weeks—in fact, in Glasgow, East Renfrewshire and West Dunbartonshire, they have been in place for almost a month. I believe that it would therefore be reasonable at this point to gauge their efficacy, so my question is a basic one: are the restrictions working, and are we seeing a reduction in transmission of the virus?

Jeane Freeman: I will say a few words, and then Jason Leitch can give a more detailed response.

Overall, with regard to non-student-related cases in Greater Glasgow and Clyde, we are seeing what has been described as a blunting of the rise in the number of cases. Of course, we have to be clear that the student-related cases have added to the number of cases with which the health board, the local health protection team and test and protect are dealing. We have not quite got to the point at which we are starting to see the number of non-student cases dip, but we are seeing a blunting of the rise.

At this point, and as a layperson, it is probably appropriate that I ask Jason Leitch to explain exactly what blunting looks like and where he thinks we are now with those restrictions.

Professor Jason Leitch (Scottish Government): It is a tricky question to answer definitively as yet, partly because of the mixed picture that we now have in light of the outbreaks

in higher education. The only way in which we can really provide that information is by separating out that young age group, although that would be not definitive as they might not all be students—some might be in workplaces. We have to take that group out and look at it.

The national incident management team has done that, and it continues to do so, to the best of its ability. Its position remains the same, in two respects. First, the acceleration is slowing but the numbers are not tipping over, so we are not yet seeing a reduction in the R number. Secondly, the team thinks that the restrictions are appropriate. That is a public health position, not a decision—it is public health advice from the local teams in the seven local authorities, who have suggested that the position remains the appropriate one for that population. You can then see us take most of those restrictions and apply them nationally, using the advice of the national advisers.

We are hopeful, therefore, but we cannot give you a definitive answer—I add only that that does not surprise me; unfortunately, with this virus, four weeks of restrictions is not long enough. If we were talking about norovirus, which has a 12-hour incubation period, I would already know the answer, but Covid-19 has an incubation period of seven to 14 days. Therefore, two incubation periods could be four weeks, and three incubation periods could be six weeks.

If we look at Spanish or French data, we can begin to see the move through the population in incubation-period chunks. No matter what we do with population interventions, there is nothing that we can do about the incubation period of this particularly nasty virus. We have to do what we think is appropriate for—unfortunately—a longer period of time than the population would like.

That takes us back to one of your earlier questions, convener, when you asked about the pace of decision making. This is the only bit that I cannot guarantee: I can guarantee that we will try to be clear and consistent, but I cannot guarantee that we will not have to be quick.

The Convener: Thank you—that is incredibly helpful. We will now have questions from the deputy convener, Monica Lennon.

Monica Lennon (Central Scotland) (Lab): Good morning, everyone. I return to the issue of a circuit- breaker lockdown. I take it from the answers that we have heard that everything is under review, so nothing is ruled out. I ask for some clarity, however. Is the circuit breaker proposition under active consideration? Perhaps the Deputy First Minister could address this question: would it be necessary, to your mind, for schools, colleges and universities to be closed down for that to be effective? Perhaps the officials could say a bit more about what exactly would necessitate and trigger such an intervention. The Deputy First Minister has talked around that, but what exactly would need to be happening in the country for such a circuit breaker to be considered essential?

John Swinney: I will say a few words first, and it might be best if Professor Leitch commented, too.

Monica Lennon is correct to say that the circuit breaker concept is being explored, which is simply because we have a suggestion from the thinking coming out of SAGE that it might be an effective or necessary intervention. Of course, the Government carefully examines the material that emerges from SAGE. However, I reinforce the point that no decisions have been made to take such a step, nor have we so far had advice that such a move will be required.

The last thing that I want, frankly, is to have to close schools. We have gone to a great deal of effort, with the support of staff, local authorities, parents and pupils, to reopen our schools. Generally, that process has gone well, and attendance is high. There is very little evidence—minuscule evidence—of in-school transmission of the virus. I want to ensure that we can sustain full-time education for children and young people to the greatest extent possible.

There are planned school holidays in October, as Monica Lennon will know. They vary from a week in most parts of the country to the two-week tattie holidays that will start here in Perthshire, and in Angus and Dundee, on Friday, perhaps stretching to 10 days in some local authority areas. They will take place over a three-week period, starting this Friday. The schools will be off for their normal holidays, which go ahead as planned. It is important that we have that break in the school period. Staff and pupils are entitled to it, and it should take its course.

The question of what the composition of a circuit breaker would be is one to which I cannot give an answer today, because there have been no decisions taken on that. The general thinking behind it is that it would represent an opportunity for us to slow down connections between individuals in our society.

We have already taken steps, which the First Minister announced last week, that mean that household visiting cannot take place across the country. That measure aims to slow down the level of social interaction in our society. I suppose that a circuit breaker could best be described as going further in that process of slowing social interaction.

Professor Leitch can provide guidance to the committee as to what would necessitate such a step.

10:30

Professor Leitch: As we learn more about the virus globally, different ideas arise. It is hard to understand how quickly we are having to learn. Nobody has ever done this before. It is important that people do not underestimate the challenge that advice presents, never mind the challenge of decision making. Not only has there been no decision about a circuit breaker, as the Deputy First Minister correctly said, there is as yet no definitive advice about a circuit breaker from pretty much anywhere in the world.

Let me go back to what the idea is. It comes from other countries, and other countries are considering it. If the R number in a country is somewhat over 1—actually, probably not too high, but just over 1—could that country put in place a stay-at-home order for two to three weeks that would buy it time going into the winter by slowing or decelerating the pandemic? The country could then go back to wherever it was in its route map or journey out of the virus, and it would have bought itself a period of time to allow it to get through what will be a hard winter period.

Nobody has ever done a circuit breaker and nobody has lived through one, but there is modelling. Most of the models involve a fairly extreme version in which people stay at home unless it is essential for them to move. That is with or without schools being closed—the Deputy First Minister is correct that modelling has been done with schools open and with schools closed. Some countries model the approach with hospitality open and with hospitality closed. All those variables have to be taken into account. There is modelling that suggests that, if you do it for 14 days, you might buy yourself 28 days of lower risk in your pandemic. You then have to make a choice using your modellers, demographics and communication ability with your population to decide whether that is the right thing to do.

My final point is that a circuit breaker is not the answer; the answer is whole-population measures all the time until we get science that can get us out the other end. A circuit breaker would just be a potential help on the way. Some modellers suggest that it should be done repeatedly—we should do it for two weeks, reopen for a period and then have another two-week circuit breaker. However, that has implications for the economy, society and schools, which have just been illustrated.

There is a very difficult balance in deciding whether to recommend that new iconic measure for Scotland. The decision makers—Mr Swinney and Ms Freeman—would then have to actually decide whether or not to do it. It is not the whole answer, but it might be part of an answer.

Monica Lennon: I want to press you a little on what the figures might be. You mentioned the R number. When the modellers do scenario planning, what figures will be taken into account? Will it be a big spike in cases, a big increase in people going into hospital or more people dying from the virus? What package of triggers will be looked at when it starts to feel as if the situation is getting out of control? Clearly, we are not yet at that point, but we could be in two weeks' time. What would tip us over into feeling that a circuit breaker had to be triggered?

Professor Leitch: Predictably, there is no single trigger. An assessment of the state of the pandemic across the UK and across Scotland would have to be made by a number of advisory groups, such as the joint biosecurity centre, SAGE and Scotland's versions of those, as well as by individual advisers such as me, Gregor Smith and Fiona McQueen, the chief nursing officer. That would then go into our command structure—if you will forgive the expression—and to the Cabinet Secretary for Health and Sport and others. The list is not dissimilar to the one that you just gave: the R number, the prevalence rate, the number of outbreaks, the ability for test and protect to manage those outbreaks, the overall number of cases and the positivity rate.

However, it is important to say that a circuit breaker is not something that we will do if the pandemic gets out of control. If that happens, the public health advice will be national measures to restrict movement and engagement between households. We are not out of control, but we are accelerating. That is a very important distinction. Just now, we are relying on human behaviour and test and protect. If those two things can manage the acceleration and tip us back over to reducing numbers, more national measures will not be required.

We are not sure, and no country is sure, whether it is the case that, if the R number is 1.3 or 1.4, a temporary measure—a circuit breaker—could be introduced that would get it down quickly and allow us to buy time going into the winter. That is what the modellers are working on just now. They have a variety of scenarios to present to the decision makers about whether that should include schools, tourism or hospitality, or whether we should not do any of that but continue with the approach that was illustrated by the cabinet secretary—national restrictions across the whole population, which is horrible but easy to explain, to reduce transmission across the whole nation.

Monica Lennon: That is very helpful, Professor Leitch. About a week ago, the First Minister said that if she had more levers—more borrowing powers—she might wish to go further with the curfew on hospitality and perhaps close the pubs

entirely. With the possibility of interruptive action in mind, I ask the Deputy First Minister whether it is the Government's view that pubs should still be open. If there has been hesitation due to the financial impact on businesses, because the Government does not feel that it can do enough to support them, how much would that influence your thinking around something like a circuit breaker? Would you need additional support from the UK Government?

John Swinney: Throughout our discussions on the pandemic, our approach has sought to address the four harms that we identified in the framework back in May. Within the framework is the whole question of economic harm to individuals and businesses. We make an assessment based on what it is possible and practical to do that will have the greatest impact on all four of those harms. Clearly, if we face a situation in which the prevalence of Covid is accelerating to a great extent, there will be little debate, frankly, about what needs to be done. We will just have to address the circumstances if the rate of spread of the virus goes too fast. Decision making becomes far sharper when the prevalence is higher.

The question of financial support is an important element in deciding what we can do. If, for example, we had more financial flexibility, we could take more moves to get the R rate down to a greater extent in a shorter time. We have to take account of the fact that, if we took those measures without financial support for businesses, we might create more economic harm to individuals. We need to balance that against the prevalence of Covid, in the decision-making process. Having more financial flexibility would undoubtedly enable us to exercise more choice and judgment, but I reassure the committee that, if we see the prevalence of Covid moving to such an extent, we will take action to ensure that the population is protected from that growing prevalence.

Monica Lennon: Thank you.

Stuart McMillan: My questions are for the Cabinet Secretary for Health and Sport. It was announced yesterday that an additional £1.1 billion will be allocated to the national health service boards and local health and social care partnerships. Will you provide information on how that money is to be invested and spent? Is it to help with the remobilisation of NHS services, in particular?

Jeane Freeman: The £1.1 billion has been calculated on the basis of two elements. The first element is each individual health board's additional quarter 1 expenditure on measures that were necessary in order to respond to the pandemic and on each health and social care partnership's evidenced additional expenditure for the same purpose.

The second element is that, in consultation with the health and social care partnerships' chief finance officers and the boards' chief executives, we have built in a projection for the coming months. Included in that is additional resource to help to remobilise the NHS, bearing in mind that we also have two other significant asks of our health boards—to support the NHS test and protect programme and to be the lead organisations in the delivery of the expanded flu programme. All those factors are in play.

The way in which the resource will be disbursed is relatively new. It is essentially a hybrid approach whereby we will use the NHS Scotland resource allocation committee—NRAC—formula in relation to our health boards and recognise that some of the boards have been disproportionately affected in terms of their response to the pandemic and the necessary expenditure. Where there has been expenditure beyond what the NRAC formula would give them from the £1.1 billion, that will be met, too. The health and social care partnerships will be paid against actual expenditure with, again, that assurance for the coming months.

As I am sure that you know, I also said that we would return to the matter next January and we will look to make an additional allocation at that point.

Stuart McMillan: Thank you—that is helpful. I am sure that those who are watching the meeting will find that information useful, too.

My next question is about services that are provided in smaller hospitals. It appears as though there has been an approach whereby the larger hospitals have more services. That is fully understandable, given their additional capacity. Is there an expectation that, with the remobilisation, more services will be rolled out across the smaller hospital estate?

Jeane Freeman: I will make two points in response to that. Our larger hospitals do not have more services just because of their size and their having more capacity. The approach is clinically driven. Therefore, where we have a need for a service that, given the volume of demand in a particular population area, would not be as clinically viable as it would be if we multiplied the demand in, for example, three different population areas, we will get clinically better outcomes by dealing with the three population groups in one location.

In orthopaedics, for example, one of the central tenets behind the elective centre programme and approach is that the ability to do high volumes of procedures produces better outcomes for patients and significant improvements to the procedures

not only in terms of what clinicians learn and do, but in terms of the time that people spend in hospital, pain relief and a range of other measures that come from that higher-volume throughput.

10:45

Those are the two rationales for why we would cohort some services in larger hospitals. That said, one of the major requirements in the remobilisation plans that I have commissioned boards to undertake is to secure a significant focus on primary and community-based healthcare. That reinforces the approach that we have had for some time to shift the balance of care, and it follows through on two main themes of the programme for government's commitments to have an excellent public health service and a greater focus on population health. It also capitalises on some of the innovations and improvements that have emerged as a consequence of the NHS's response to the pandemic. I am thinking, in particular but not exclusively, about the use of digital technology and the expansion of the hospital at home programme, in which individuals, many of whom are elderly, receive treatment at home from clinicians and others. If that service was not available to them, they would require hospital admission.

The focus is on primary and community care. I hope that that is a helpful explanation of why some services are cohorted into our larger hospital estate.

Stuart McMillan: My final question is on dentistry. There is a fallow period of about one hour between a dentist seeing each patient. Has anyone looked at reducing that period? That would allow more patients to be treated.

Jeane Freeman: The chief dental officer looks all the time, with our other clinical advisers and the professional bodies, at what more we can do to increase the level of service that our NHS dental practices offer. That includes considering whether the time for necessary cleaning and so on to ensure patient and staff safety can in any way be reduced while still remaining safe and examining whether we can bring in the full range of NHS services more quickly. That work is under way, and I hope that we would be able to reach a conclusion on both of those issues shortly.

Mark Ruskell: There is an objective in the universities and colleges guidance to reduce the number of people on campus. How is that going?

John Swinney: The Government's guidance made it clear that we envisaged an approach of blended learning being undertaken, so there would be elements of face-to-face teaching and online learning, and that universities and colleges would be exercising judgments about the number of individuals that they could have on campus, based on taking the range of mitigating actions that are set out in the guidance.

Mark Ruskell: I thank you for that response, but we are still hearing concerns about the nature of blended learning and the number of people who are on campus. You will be aware of the concerns from staff at Perth College about a resumption in face-to-face teaching and about attendance on campus. You may also be aware of the situation at the University of St Andrews, where there is continuing disagreement between staff, unions and management about the phased reintroduction of face-to-face teaching. When I raised that concern with the First Minister, she said that staff should not be

"put under pressure to do things that we do not advise."—[*Official Report*, 26 August 2020; c 18.]

What is the Government's ultimate advice? Is the advice still that, where possible, the default should be working from home? I am seeing a resumption of face-to-face teaching, and, at the moment, our campuses are full of young people, although they are locked down in student residences.

John Swinney: The guidance envisaged that there would be a blended learning approach, which I set out in my earlier answer. That approach involves an amount of face-to-face learning, but my assessment is that that is being kept to a limited level. That is the appropriate step to take, which is consistent with the guidance that the Government has issued.

The importance of high-quality dialogue between employers and their employees about the approach to be taken cannot be stressed enough. That goes to the heart of our whole approach not only in the university and college sector, but in every sector of our society. We will make much more progress in dealing with the practical implications of Covid, and the recovery that we must make from it, if there is a good, positive partnership approach to the resumption of activity, through which the concerns of members of staff are taken into account and reflected in the approaches that are taken.

I stress that the guidance that has been put in place involves a series of mitigating actions and that it is important that those mitigations are followed to make sure that we are creating a safe environment for everybody who is involved.

The teaching environment in our universities and colleges will be very different to what is was pre-Covid, and there is and can be no resumption of the large-scale lecturing environments of the past. We simply cannot have that many people together in the same place at the same time. The

guidance envisages, for example, much lower limits on the number of individuals who can be educated together, and it is necessary to have strict mitigating factors in place if such teaching is to occur.

The key points are that the guidance must be applied in its entirety, and that good and high-quality dialogue between university and college leaders and staff is essential in progressing the approach.

Mark Ruskell: I look forward to an improvement in the high-quality dialogue in some of our institutions, which seems to be lacking.

On testing, I read last week that the University of Cambridge is moving to a regime of testing all students weekly, regardless of whether they have symptoms. The university is doing 16,000 tests weekly. It is not using the UK Lighthouse Labs Network; it is using its own facilities. The purpose of the testing is to try to break any chain of infection that may build up in the student community.

A number of universities are considering implementing a similar regime. Is that something that we are considering in Scotland? Is there a danger that we might get left behind? Where we can do so, and where people are at a higher risk of infection, should we not be focusing on testing people who are asymptomatic?

John Swinney: I will say a few words, but it would be better if Professor Leitch or the Cabinet Secretary for Health and Sport said more about that, because they are close to all the policy issues on testing.

From a higher and further education perspective, our policy approach has been consistent with that taken on testing as a whole, as agreed by Government and based on public health advice. Fundamentally, that has been to test symptomatic individuals, for the good reason that, in our strategic approach, asymptomatic testing has been judged not to be a particularly valuable use of testing resources, given that it does not necessarily provide us with an assurance of what other measures and circumstances should be addressed as a consequence.

We have in place adequate testing resources for those who require tests. We are expanding capacity, and I am grateful to the health secretary for the priority that she has given to the expansion of that capacity in locations convenient to our university communities. That expansion has happened in St Andrews, Glasgow and Edinburgh; in a few days, additional capacity will emerge in Aberdeen and Stirling, and there will be roll-out beyond that. The availability of testing capacity has been an important priority.

I will hand over to the health secretary, or to Professor Leitch, to give extra detail on the efficacy of asymptomatic testing.

Jeane Freeman: I will make a couple of points, after which I will ask Professor Leitch to add to what I and the DFM have said.

The DFM is absolutely correct. Our revised and refreshed testing strategy was published in the summer. It makes clear the basis on which we approach the use of testing as one of the steps—it should never be seen as the only step but as one of our tools—in understanding what is happening with the virus, in attempting to appropriately clinically treat those individuals who have symptoms and test positive, and in capturing those with symptoms, primarily through the test and protect programme, and through the app, which has been downloaded 1.3 million times.

We test asymptomatic individuals in one specific case: our care home staff testing programme, which tests an average of 37,000 staff weekly. That is to prevent the introduction of the virus into care homes, where we have our most vulnerable citizens, who are more vulnerable to harm, more likely to become seriously ill and more likely to die as a consequence of the virus.

The Deputy First Minister has also said, quite rightly, that we have introduced walk-in centres in St Andrews, Glasgow, Aberdeen and Edinburgh. The Stirling centre will open next Monday, the second Glasgow centre will open this Friday and we will then move on to Dundee. We will then pick up other parts of the country—for example, Inverclyde, parts of the Highlands, and West Dunbartonshire—where the measures are less to do with the concentration of the student population and more about making testing resource more accessible.

You will be aware that we have two testing routes in Scotland. In the first of those, samples are processed through the UK Lighthouse Labs Network. The other is through our NHS labs, which have been scaled up. The introduction of regional hubs will significantly expand our capacity to process samples through the NHS. That will allow us to complete the current programme of work, which is migrating our care home staff testing from processing through the Lighthouse lab, which is subject to reductions in processing capacity for tests that are taken in Scotland as a consequence of surging demand in the UK as a whole, and ensuring and protecting the processing of those samples from care homes.

11:00

As we expand the capacity to process tests in Scotland through the NHS, we will continue to consider what more we can do to use testing as

one of our tools to interrupt the transmission chain of the virus and protect our citizens.

Professor Leitch may want to say something about the approach to testing asymptomatic individuals.

Professor Leitch: I thank Mr Ruskell for his question. I do not know the Cambridge story specifically, so we should look into exactly what that university is doing. I am guessing that it has also introduced considerable travel restrictions on the student population. Cambridge students tend to live in campuses behind gates. Asymptomatic testing in bubbles makes more sense than asymptomatic testing outside bubbles, where people still engage in society. There is asymptomatic testing inside bubbles for elite sport, but people are not allowed to leave the bubble to go to the chemist, for example.

There are, of course, ways in which asymptomatic testing can be used, but let us remember what the test does. The test looks for genetic material of the virus—either live virus or remnants of live virus, which people can shed for up to six weeks following infection without being infective. There are extensive limitations to the present version of testing.

One of the ways out of the pandemic is through a different, quicker and more reliable form of testing that could be rolled out at a population level all over the world, from Palestine and Israel to Scotland. We do not have such testing just now.

Asymptomatic testing has a role, and we seek advice on how we should use it from virologists, the scientific advisory groups, the education advisory group and SAGE. We bring all the evidence together and compare it with our capacity, because, even though we are now at the top of the European league table on testing by population size, there is still finite capacity for testing. We then give advice about choices, and the advice about what we think the priorities should be is laid out in the testing strategy that we have published a number of times—most recently, just a few weeks ago.

All that said, we keep the advice under constant review. We will pay attention to what is happening at the University of Cambridge and at Duke University in North Carolina, which is doing a similar programme. If there is learning from those universities that influences such decisions, we will, of course, think about that and advise appropriately.

Mark Ruskell: Those were very useful responses. It is clear that some Scottish universities have more of a bubble around them than others do. That is particularly the case with the University of Stirling, for example, which has a campus away from town. It would be very useful to hear about anything that the Government can do to roll out more asymptomatic testing.

Professor Leitch mentioned rapid testing. This week, we heard the news that the World Health Organization is assessing for use a number of rapid tests, and that it aims to make 120 million such tests available in low-income countries. When do you think rapid tests will be available in Scotland?

Professor Leitch: Unfortunately, it is not a case of the current test versus the new, fancy three-minute test. There will be scientific progression through testing. Traditionally, as we miniaturise and speed up, we lose specificity. As we get smaller and quicker tests, tests get slightly less reliable, so they tend to be used at population level to inform decisions not about individual treatment but about population restrictions, for example. Such testing might well come quicker than tests that people can use at home and which give a red or green message to let people know whether they can go to work that day. That is a long way off, despite what we read in some journals and media.

We are already testing faster tests. We are already assessing some machines and giving them to our laboratories. We can do things such as let the PCR—polymerase chain reaction—tests proceed as normal and use the same sample in one of the new machines to see whether we get the same results as the drug companies or the manufacturers suggest we can get using their machines. That is on-going and happens all the time with tuberculosis testing, sexually transmitted disease testing and others. We are speeding that process up and investing in what we believe at the UK level is the best hope, which is the best version of that approach.

Then, with the WHO, which is procuring for the whole world, and all the drug companies coming together scientifically using the universities in Edinburgh and Glasgow and others, we are working to make the research better so that one day—and this is the moonshot idea that you have read about in the papers—there might well be a test that people can do at home for this coronavirus, as long as it does not mutate away from us, that will tell them whether they have it on that day. Just now, we simply do not have the science to do that.

My final point is that fast testing will be best at bedside. We will use fast testing first on the treatment of people who have Covid. Let us remember that, in among all the asymptomatic testing of students and all the talk of care home testing for staff, the most important people are the people who have the disease. Everything that we can do to help them should be our number 1 priority; then we should stop people getting the

disease, which is the next thing that we will use testing for.

The Convener: The evidence session is taking slightly longer than expected. I hope that it is all right with colleagues and our witnesses if we drift on beyond 11.30. If it is not all right, and if you have an issue with that, please could you let the clerks know or type it into the event chat. I do not want to go too fast for the members who are still to ask questions. With that in mind, I turn next to Shona Robison.

Shona Robison (Dundee City East) (SNP): I want to turn to the health harms that were identified in the route map and, in particular, the recent Public Health Scotland figures that show that cancer referrals dropped by a fifth in the three months after lockdown compared to the same time last year. Will the Cabinet Secretary for Health and Sport provide an update on the remobilisation of cancer screening services to reduce that health harm?

Jeane Freeman: One of the statistics that we published yesterday showed 96 per cent of our boards meeting the 31-day target. That has been consistent throughout the pandemic, and it deserves a mention because it shows the significant work on the part of the boards and all the clinicians involved to be able to do that while they were facing other challenges.

The screening programmes have restarted, although I do not have the exact dates in front of me—my apologies. I can provide them to you, although I think that we have published them. We have almost finalised our cancer recovery plan, which has been pulled together with the engagement of condition-specific third sector organisations as well as the clinical cancer network, and we will publish that shortly. That plan will contain specific focused action to improve the flow of patients from the screening programmes or the first appointment with the general practitioner through to diagnostics and treatment, if that is what is required.

We have also invested in additional CT and MRI scanning facilities to make sure that we can speed up the diagnosis of cancer as well as other conditions as quickly as possible. As you will know, we are using NHS Louisa Jordan to provide early appointments and treatment, not for cancer, but certainly as early diagnostic facilities.

Shona Robison: That is a most helpful update—thank you.

I would like to ask you for an update on another matter: communication with the UK Government on pandemic-related matters. Are meetings happening involving ministers from all four nations? If not, why is that the case? When did you last meet UK Government ministers to talk about the pandemic?

Jeane Freeman: I can answer that from the point of view of health ministers, and the DFM may wish to say something further about other engagement with the UK Government.

There are relatively regular meetings between the health ministers from Northern Ireland and Wales, myself and the Secretary of State for Health and Social Care. They were taking place weekly, every 10 days or every fortnight, in addition to the constant engagement between our officials. The ministerial meetings tend to involve just the four of us, perhaps with one or two officials in attendance, and we look to share experiences and ideas, as well as tackling particular problems.

It may be helpful to offer one specific example. It was very helpful when I was able to speak to my counterpart, Vaughan Gething, the Minister for Health and Social Services in Wales, about the experience there with the 2 Sisters outbreak, before we experienced a similar outbreak in Tayside involving the same company. It was helpful to be able to speak to Vaughan about the Welsh Government's engagement with that company and how it had approached the situation.

As you know, our test and protect app has been built using significant support from colleagues in Northern Ireland and the Republic of Ireland, and I am pleased to recall our capacity at the height of the first period of the pandemic, when, through mutual aid, we were able to provide PPE to both NHS England and NHS Wales.

John Swinney: I will add something on wider Government engagement.

It would be fair to say that engagement varies a bit between different parts of Government. There is a good amount of dialogue and discussion in a number of portfolio areas. The Cabinet Secretary for Health and Sport has talked about her dialogue in the health portfolio, and I have had a number of discussions with the UK Government's Secretary of State for Education and my counterparts in Wales and Northern Ireland. The Cabinet Secretary for Justice is involved in discussions that, thankfully, have become a bit more routine regarding some of the issues relating to the quarantine arrangements and the exempt list for travel. There are other engagements taking place, too.

The area on which we have expressed concerns has been the rather significant absence of COBRA discussions. Thankfully, however, that was resolved and remedied in recent days.

We attach a high importance to dialogue with our counterparts in the other devolved

Administrations and the UK Government, and we participate whenever it is possible to do so.

Shona Robison: I ask the Deputy First Minister to give us a couple of pieces of information about the very welcome announcement that was made today about the new financial support package for people on low incomes who are having to self-isolate and who would otherwise lose income.

As I understand it, the £500 in support grants would be paid through the Scottish welfare fund, through local authorities, beginning on 12 October. As I say, that is very welcome. Will further guidance be provided for the use of that package and to ensure that the demand is monitored? What work will be undertaken with employers to improve some of the employment working practices that have perhaps led to that grant—very welcome as it is—having to be established?

John Swinney: Further details of the payments that are intended to be made will be set out by the First Minister at the briefing later today. Obviously, we are determined to put in place the support that will be necessary to assist individuals at what is a difficult time. We certainly do not want a situation in which people feel that they are unable to self-isolate—which is the building block of our strategy for interrupting Covid—because they feel that they are financially unable to do so.

The provisions will be put in place, and we are working at pace to ensure that they can be delivered in the earliest course, because they are part of a crucial intervention. We are working with employers to ensure that employment is made as sustainable as possible. We face a challenging period with the changes to the furlough scheme that are coming forward, and it is vital that we have all the practical measures in place that can ensure that individuals are supported to play their part in the interruption of coronavirus.

11:15

The Convener: Willie Rennie will ask the next question. Willie, if you have any interests to declare, could you do so before you ask your question?

Willie Rennie (North East Fife) (LD): I have no relevant interests to declare. Thank you for giving me the opportunity to take part in the meeting this morning.

The Scottish Government changed guidance for students days before the start of term and then chopped and changed the advice after students had already gone to university. I am sure that the ministers understand that that has caused unnecessary stress for many students, many of whom have just left home for the first time.

Some universities are not handing back the rent money if a student returns home. Are ministers prepared to step up and provide that level of support so that every student in the country can benefit, whether they are in private accommodation or other halls of residence?

John Swinney: Fundamentally, these are decisions for individual institutions to make. Obviously, we encourage institutions to operate in a fashion that is sympathetic to students at what we recognise to be a difficult time.

Our core advice to students is that, if they are able to do so, they should stay in the campus accommodation to which they have moved. Some of them will have moved there some time ago, over the summer. Many of those movements have been made because arrangements were put in place long before the Government set out the guidance.

However, we also insist that universities provide the support that is necessary to individual students, particularly if they are self-isolating, to ensure that they are supported in maintaining that self-isolation and in having all their needs met, whether they are physical needs, support with cleaning and laundry, mental health support, medical support or whatever. We insist that universities consider that to be an essential part of what they do to support individual students.

Willie Rennie: I encourage the minister to look again at this matter. Obviously, universities that have control over their own halls of residence can support students through the rent mechanism, but there are many students who are in private accommodation and there are many universities that do not have the financial flexibility to offer that kind of support. Fundamentally, the problem is caused by the chopping and changing of the guidance over the weekend.

I want to move on to the issue of asymptomatic testing for students, which has already been covered. I am frequently told, including by the First Minister, that the concern is about resulting behaviours from negative tests. The assumption is that students and others will relax and ignore all the public health guidance if they get that negative test. I am keen to understand where the evidence is to justify that position.

John Swinney: I will respond to begin with, and my colleagues may wish to add to what I say.

The health secretary made a point—in her opening remarks, I think—about the importance of listening to the advice that we receive on behavioural science. We have had tremendous input into the Government's thinking from Professor Steve Reicher from the University of St Andrews, who has contributed significantly to our understanding of the importance of people feeling

confident in the requirements that are placed on them and able to play their part in taking forward the guidance that is set out.

As I said in my opening remarks, much of our success in dealing with Covid will come down to the contribution of individuals and the degree to which they comply with the guidance. I cannot stress enough the importance that we attach to ensuring that there is good understanding of and compliance with the guidance that has been set out, and that every individual plays their part in that activity.

On the issue of asymptomatic testing, our judgment is that asymptomatic testing may make people feel that they are not quite as obliged to follow the guidance as we would ordinarily expect them to feel. That applies throughout the population. We have put out the guidance and we feel that we should apply a strong message so that individuals see the importance of contributing on a daily basis to keeping themselves and others safe.

Jeane Freeman: I want to make a couple of points, and Professor Leitch may have more to add.

We have to take a bit of a step back here and remind ourselves what we are actually trying to do. Until we have a vaccine that has been clinically trialled, proven to work and rolled out across the population, we are trying to prevent the transmission of the virus from one individual to another. We need to go back to the simplest and most straightforward steps that each of us can take: washing our hands regularly and properly; cleaning hard surfaces; using face coverings; and maintaining a physical distance of 2m. Those are the important steps that each of us can take to prevent the virus moving from one person to another. It is the core public health advice—the core tools, if you like, that each of us has.

Testing is added to that in specific circumstances where it is appropriate and valuable. It is valuable in care homes in preventing the introduction of the virus by the people who go in and out of care homes regularly—in other words, the staff. We use testing in care homes every week on individuals who do not have symptoms, because, from time to time, such individuals prove to be positive. However, the number who prove to be positive compared to the total number who are tested every week is very small.

Testing in itself is not enough. As well as all the other measures that I have described, individuals in those instances need to do all the work around PPE, effective infection prevention and control, and barrier nursing. I am trying to help us remember the place that testing has. It is not a silver bullet. Following the basic public health advice and guidance is the closest that we have, individually and collectively, to any kind of silver bullet.

Professor Leitch has already spoken a bit about asymptomatic testing. He may want to add some more points to what I have just said.

Professor Leitch: I refer Mr Rennie to the previous answer, but I will add one layer, which I think the Deputy First Minister and the cabinet secretary have touched on.

There is a behavioural element to testing—there is no question about it. There is the science, the genetics and the bit that I covered earlier, but there is a perception, in all layers of society, that if a person tests negative, they can go about their normal business. We know that. Students are not special in that respect, and I am not singling them out in any meaningful way. I am not singling out any section of society.

If we introduce testing to some new layer or group, we have to be very clear what that test means and what someone should do in light of a negative or positive test. That is true of a mammogram, a CT scan or a PCR test for the coronavirus. That communication is crucial. Unfortunately, in the context of coronavirus, a negative test is relatively meaningless in relation to an individual's behaviour: they should still self-isolate if they are a contact and continue to adhere to the population measures that we are all under. That is the challenge in relation to behavioural science, as well as the genetic science and the PCR science on what the test actually tells us.

Willie Rennie: I have one more quick question. Given that a large proportion of those who have got the virus do not know that they have it, should we not be using testing, especially for young people such as students, to try to hunt down the virus more? Is that not what we should be using testing for? I agree with everything that Jason Leitch and the Deputy First Minister have said about how testing is not a route to going back to normal life as it was before but is an extra safety measure. My argument is that, because this is the biggest movement of people since the start of the lockdown, we need to take an extra step just now to try to snuff out the virus in universities, on top of all the public health measures that you have talked about. Is there not an argument for doing that?

John Swinney: I contend that, given the number of tests being undertaken, much of what Willie Rennie suggests is already happening, because of the degree to which increased testing is taking place in several locations, particularly with the welcome addition of the walk-in centres, which have been established in several locations in close proximity to universities. The improved

availability, accessibility and volume of tests contributes significantly to addressing the point that Willie Rennie makes.

If we add to that the very strong message that we are sharing, in consort with universities and, crucially, with the National Union of Students and student associations, on encouraging good practice and following the advice, that should give us some confidence that we are taking the measures to do exactly what Willie Rennie wants us to do—and I want us to do—which is to ensure that we take all possible steps to contain the virus within those university communities, to eradicate it and, most important, to avoid it spreading to wider society.

Jeane Freeman: I have nothing more to add to that.

Professor Leitch: I would add only a single point. We asked our scientific advisory groups the exact question that Mr Rennie has just asked and the advice that came back to the Deputy First Minister was, at this stage of the pandemic—it is under constant review and will of course change if testing at the University of Cambridge proves something different—that we should not pursue asymptomatic testing but should send in more symptomatic testing, which we have done around Abertay University and the University of Glasgow, with mobile testing units, walk-through centres and so on. The advice was for layers of testing, but not that population-level asymptomatic testing.

11:30

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I have a couple of questions for John Swinney and Jeane Freeman from constituents, about the household and hospitality restrictions, and if there is any time at all, convener, I have a question on the R number for either Jason Leitch or Richard Foggo. Why is it that we allow people effectively to be in the company of many other people in restaurants, pubs, planes and buses, all breathing the same air for longer than 15 minutes but we do not allow a person to visit another person in their house? On the 10 pm hospitality curfew issue, if we are in a pub or restaurant for a few hours, why is it that we think we are safer if we leave at 10 o'clock than we are if we leave at 11 or 12 o'clock? Those are questions that constituents have been asking me this week; I would be obliged if you could try to set out your thinking about why those measures are necessary.

John Swinney: I will respond to that first. Essentially, the decisions that we have taken, particularly on household restrictions, which I can assure Mr Coffey that we have taken with great reluctance, have been driven by the fact that there is a growing evidence base in Public Health Scotland's work that demonstrates that household transmission is a significant factor in the spread of the virus. We are reluctantly having to put those restrictions in place in a very targeted way to address an element of transmission that we know from the evidence is causing significant difficulties.

People from two households can meet up in a cafe, pub or restaurant, but those businesses are obliged to follow their regulatory requirements and very strict practices about how they deliver their services and manage their environments, which cannot be assured in a household setting. That is the distinction on that particular point.

On the 10 pm issue, the sense that I want to convey to Mr Coffey is that we feel that there are limitations and parameters that we need to put around the degree of interaction that individuals can have. If that interaction goes on on an unrestricted basis, it might give a signal or an opportunity for the virus to be transmitted, but if we put some constraints on it, we enable people to undertake some social interaction without the interaction being limitless and therefore challenging. My colleagues will wish to add to that.

Jeane Freeman: I will make two points. The first is to reinforce what the DFM just said; when we undertake the NHS test and protect procedure, we find that, as index cases are interviewed and people tell us where they have been, how long they were there and so on, what Professor Leitch has described as "themes" emerge. Essentially, we begin to see commonalities in how individuals acquired the virus, where they have been with their contacts and so on. That is a key way in which evidence emerges about what looks like one of the dominant areas where transmission happens—which has consistently been shown to be households.

I am sure that Mr Coffey knows that many constituents and family members have asked me exactly the same question, and I understand that it is normal to think, "My house is clean and I look after everything, so why can't people come and see me in my own home?" It is because our own homes are not—nor should they be—regulated environments in which we strictly maintain 2m distance and are very careful all the time about how we clean surfaces that other people have touched. Mine would not be a very welcoming home if I followed everyone who came to visit around with an antibacterial wipe, wiping everything that they touched immediately after they touched it.

Therefore, I understand the reaction, but that is the core explanation. The difference between our own homes and hospitality environments is the regulation of physical distancing, sitting at tables, wearing face coverings, taking contact details and all that.

That is alongside the fact that the evidence is telling us that, at this point, one of the most predominant areas of transmission is household transmission. If we want to stop that, we have to impose those kinds of restriction on all of us. It is very difficult advice indeed to receive and follow, but it is necessary if we are to succeed in preventing the virus from getting out of control.

Willie Coffey: Those were very helpful answers, John and Jeane.

I have another question, which is for Jason Leitch or Richard Foggo. If the virus can accelerate from really low numbers to very high numbers in the population in a short space of time, how can we ever be in a position in which it is no longer regarded as a public health risk, such that we can move to phase 4? Are there any countries that we know of that are now at the equivalent of phase 4?

Professor Leitch: What a fantastic question, Mr Coffey.

There are no countries that are at phase 4. There are countries with lower prevalence than us. New Zealand is the obvious example, and there are countries in south-east Asia that the WHO is looking at very carefully, but even in those places importation of cases remains a challenge. We have seen Auckland close down in the past six weeks, as well as Melbourne, in Australia, which had very low numbers.

Until we get a clinical and scientific breakthrough, we are stuck with this virus, and even at that point it will be endemic and we will have to live with it, just as we live with flu, tuberculosis and other infectious agents. I think that we will live with this virus for many years. However, we will live in different phases. I am very hopeful that, in the spring and summer of 2021, the world will develop a vaccine that will partly protect maybe all of us and maybe some of us, against the worst elements of this virus. However, it will not kill the virus in the community. We will not get to a position in which the virus no longer exists. The only thing that will get us there is the virus doing something—that might happen, and if we are going to wish for something that is what we should wish for, but there is no evidence that the virus is changing to get us into that position.

The only way out is through a mixture of testing and treatment. Currently, we have no way of stopping a mid-level case from becoming a very serious one. We have no way to prevent people from getting the disease, other than through their own behaviour, and we have no way of treating the disease if a person gets it, except—right on the extreme—if they are in intensive care, where we are getting a bit better at keeping people alive and getting them out safely. There is no meaningful treatment earlier in the journey. There is also no treatment for those who get the chronic disease from this viral infection, because we do not understand it yet.

Therefore, until then—and we have said this a number of times—it comes down to human behaviour and test and protect. The reason why you see me and my colleagues being so worried about 600, 700 or 800 people getting the disease is that that has implications for serious illness, and the health service cannot get us out of that situation.

Maurice Corry (West Scotland) (Con): Good morning, and thank you for coming to our committee.

I have a question for the Deputy First Minister, which follows on from Willie Rennie's earlier question in relation to negative tests. As we enter the second six months of the pandemic, people could become complacent, weary and slack about adhering to the necessary restrictions. What is the Scottish Government's plan to counteract that with clever and effective communications?

John Swinney: I acknowledge the significance of the point that Mr Corry makes. The Government has taken a range of steps to make sure that we continue to maintain the clearest possible communication about the risks that people face and the compliance that is required to enable us to defeat the virus.

That communication takes a number of forms; first, it relates to the conveying of public information by the First Minister on pretty much a daily basis, which we have sustained throughout the pandemic and believe to be very important. The broadcasting of that to the wider population is a significant part of that communication message.

Secondly, we have significant advertising and marketing campaigns, which are designed to reach different groups, to encourage compliance. Crucially and thirdly, those advertising and marketing campaigns are informed by significant research into the attitudes that prevail among individuals about the risks that they face and the necessity for their compliance.

Obviously, if public willingness to comply is beginning to wane, we will have to rebalance the marketing to reach the people who might be less likely to comply. Colleagues might have seen the recent advert, in which paint is used to symbolise the virus being conveyed between a young woman and her grandfather; I contend that that is a noticeably blunter and more aggressive communication about the dangers. That advert was designed as a consequence of our market intelligence, which indicated that compliance was not as acute and that there was not the sense of the danger of household transmission, which we

have just discussed in response to Mr Coffey's questions.

Fourthly and finally, we have anchored our message around the FACTS guidance that has been reiterated and reiterated; we will continue to do so, because that is the foundation of the actions that we need from individuals to ensure compliance.

Maurice Corry: Thank you, Deputy First Minister; that is very interesting. As a marketing man, I understand the messaging that you are talking about and I think that it is absolutely right.

Professor Leitch made a clear point in answer to Willie Rennie's question about people who have had negative tests still having to adhere to the pandemic measures. That message is extremely important; how will you target it? How will you encapsulate it in your messaging?

John Swinney: Fundamentally, we have to anchor all that we do around the FACTS guidance. If people observe the FACTS guidance in all circumstances, that is the best defence in relation to the spread of coronavirus. Those are not abstract marketing concepts; they are fundamental tenets of guidance that we are putting into a marketing message and reinforcing as effectively, assiduously and comprehensively as we can.

As Mr Corry knows, the challenge is that, as people become familiar with that message, they might become tired of it, so we have to find different ways of reinforcing it. I contend that the most recent distillation of that message through the paint advert is a pretty blunt way of doing that but has had the effect of reminding people of the dangers of not following that core advice that we set out to members of the public.

Maurice Corry: That is an interesting comment, and I agree strongly with what you said, because we need to drive that message home.

I have a final question for the Cabinet Secretary for Health and Sport and Professor Leitch on care home visitors. Families are concerned about the fact that only one nominated visitor is allowed to visit a care home resident. We need to consider whether some flexibility is possible. I understand the restrictions and the consequences of exactly what the Deputy First Minister has just been talking about in spreading the disease, but could we implement a system for close relatives to visit wearing PPE? Does the Government have any plans to consider that for residents, who would benefit from visits by family members generally, in a very controlled fashion, obviously?

Jeane Freeman: That is a very important question. I am conscious of the unintended consequences of the visiting restrictions, even where those have been eased, on the residents of our care homes and the staff, as well as on families and friends. Our clinical and professional advisory group is constantly considering everything that we are doing. With that group and care home providers, we are looking at what we can do to protect residents, but also to see what we can do to introduce more normal life to care homes. The advisory group is working hard at the moment, and I expect its clear advice shortly. I had a discussion with the care home relatives group just over a week ago. Later this week, we will discuss with it what I hope will be a proposition that allows, first, for the designated visitor to be able to visit more frequently and for longer, with appropriate protection and appropriate responsibility on them not to go if they have symptoms of any infection, but particularly of Covid, and, secondly, to reintroduce touch—the opportunity to give your mum, your dad, your aunt, your brother, your sister or whoever a hug. That is very important. We all recognise very well the impact on us of the absence of physical touch from family and friends, because we are just not engaging in that at the moment.

I hope that we will be able to do that. As I know you appreciate, it is a difficult balance to ensure that we protect a group of people who are vulnerable to serious harm from the virus at the same time as recognising the other harms that can be done by that level of protection. We are trying to get that balance right. We have also allowed the return of health and care services to care homes, always with the proviso that the care home is Covid free for 28 days and participating in the care home staff testing programme, which I spoke about before.

It is a very important issue, and I am glad that you raised it. I hope that we will be able to make progress very shortly.

Professor Leitch: I would add only that, when I think of all the restrictions that we have had to advise about, that is the toughest. It is literally the hardest piece of the public health response, because everywhere you look there is harm—from Covid, loneliness, dementia and lost family connections. To try to find a compromise that gets us to somewhere in between all those harms has been enormously difficult for every country, including ours.

We have made progress, which we have tried to do gradually and safely. I can absolutely promise you that the Cabinet Secretary for Health and Sport has called in all the people she needs to in order to make those decisions wisely.

I add a fairly blunt statistic in balancing my desire to get families—and myself—back to friends and family who are in care homes. Some 10,000 under-20s must be infected with the virus before someone dies, but only six over-85s must

be infected before someone dies. That is a stark warning about how crucial it is to do this safely. That is not to suggest remotely that we should leave people to be lonely and we should not look after them—of course we should, but we should restart the visiting only when it is safe to do so.

Maurice Corry: That was a stark statement at the end on the statistics.

The Convener: Our final set of questions comes from Annabelle Ewing.

Annabelle Ewing (Cowdenbeath) (SNP): It has been an interesting discussion. The take-outs are fairly gloomy, but that is where we are.

I had a number of questions, but they have been asked and answered, so I do not want to delay everyone unduly. [*Inaudible*.] I am thinking in particular of—this involves communication, too—the comments that Professor Leitch made yesterday during the First Minister's daily briefing, which I was struck by. When he was informing and reminding us that this is a global pandemic, he provided us with an update on the statistics from across the world on the number of cases and, sadly, the number of deaths, and with examples of what is happening in other countries. I seem to recall that, in the early stages of lockdown, when buy-in and compliance were amazing in Scotland, we were very much aware as citizens that we were part of something that affected every country in the world. Could Professor Leitch provide such an update for the committee's purposes?

I also have a question for the Deputy First Minister. Will the Government reflect on how we can continue to bring relevant information about the international context to the attention of the people of Scotland? Sometimes, there is a risk that we feel that what we are doing in Scotland is sui generis and nothing to do with anything else. We forget that are in the middle of a global pandemic and that no citizen of the planet will come away unscathed, whether that is in terms of health or economic and/or wellbeing issues.

That is an important picture to bring to people's attention, because it helps to put things into context and it helps to facilitate compliance as we approach the winter months and we can see how weary people are getting.

Professor Leitch: I am grateful—you are very generous. Yesterday was an appropriate day to talk about the global pandemic because, in the early hours of Tuesday morning, the world crossed 1 million deaths. Some 1,000,055 people have died following a positive Covid-19 test. We know that a number of them have been in Scotland, so it was appropriate to put that into context, which is what we did yesterday. When I came home, my wife said that I was a little emotional when I was at the podium, which is unusual. Most people would not have spotted that, but she did. She was right. The issue is not without emotion.

We should not remove that from the communication or the messaging that we are trying to spread around the country, whether that is in an article in *The Oban Times* or phone-ins on Radio Scotland in the morning. Earlier, in answering questions on communication, the Deputy First Minister talked about multiple messaging to every sector. We have had to change the way in which we do that, and relating to the global pandemic is one element of that.

To put that in perspective, no European country just now is not thinking about extra restrictions. The most recent example is the Dutch, who have introduced very restrictive hospitality measures in the past few days, with groups of no more than four people allowed. The Dutch have also restricted household gatherings and banned sports crowds. Other countries have gone to allowing one household only in hospitality, so people cannot mix at all. As we discussed yesterday, in Paris and 11 other cities in France, there is now a curfew at 10 o'clock, which is not unlike ours. In the south of France, in Marseille, where intensive care units are now full, hospitality has been shut in its entirety.

France has a population of 60 million people, so we have to divide the numbers from there by roughly 10 to get to an equivalent for Scotland's population, but the number that came out yesterday from France was that there are 1,203 people in intensive care there. Our conventional intensive care capacity in Scotland is about 120 to 150, and we should remember that it is not waiting for Covid patients; it is full of people with things such as cancer or major trauma as a result of road traffic accidents. We have more capacity than that presently, because we have prepared for Covid, but a similar situation here would mean another 120 people in intensive care and, once someone is in intensive care and has that level of Covid, they have a 50:50 chance of living or dying.

My final international comparison would be with Spain. The situation there is pretty bleak, and it speaks to what Scotland is doing now, why it is doing it and why it is crucial. Nine weeks ago, in Spain, the over-80s had 8.2 cases per 100,000. Six weeks later, that figure was 75 per 100,000 cases and, three weeks later, 1,200 people died. The virus makes its way through the demographics. The over-80s are probably not out in the hospitality sector or mixing a lot in other people's households, but the virus eventually gets to them. In earlier questions, the committee asked why we are doing what we are doing now, and that is why—it is because we do not want to be the stories from France and Spain that we are watching. We can learn as we go.

I am sorry to be so bleak.

John Swinney: I will add to what Professor Leitch has said in response to Annabelle Ewing's question. I said earlier that the Government reviews data and information on a daily basis, if not several times a day. The health secretary, Professor Leitch and I have been involved in a number of discussions—I think that the most recent one was on Monday—in which we have looked directly at the French and Spanish data and compared it to our data over the past couple of months. When you plot the Scottish data against the French and Spanish data, you see that we are following a fairly similar course, although we are several weeks behind. That is the answer to the question about why we are acting as emphatically as we are acting now.

Annabelle Ewing raises an important point that the debate and discussion—and compliance—would perhaps be enhanced by sharing more of that international comparative information. I will certainly take that point away and reflect on it, but I assure the committee and Annabelle Ewing that we are looking at all that data to inform our judgments and to ensure that our actions are as effective, timely and emphatic as they need to be to protect the population from the obvious dangers that Professor Leitch has just set out.

Annabelle Ewing: I thank the Deputy First Minister and Professor Leitch for those answers. I am reassured to hear that the international data is being looked at constantly by the Scottish Government. However, greater communication of that is important, so that people in Scotland recognise that we are global citizens and that decisions taken here are not being taken in a bubble. We all have to get through the pandemic somehow and the more we pay attention and do what we need to do, the quicker we will get out of it. I am pleased that the DFM will take away the point about communication and reflect on it further.

The Convener: Does Mr Foggo want to add anything to the discussion? We have avoided coming to you, but I do not want you to feel that you have been ignored.

Richard Foggo (Scottish Government): I do not have anything to add. It is always difficult to be alongside Jason, who is such an overwhelming expert. Thank you for coming to me and for inviting me. I will be happy to contribute to future discussions, if you would find that helpful.

The Convener: Thank you, and I thank the Deputy First Minister, the Cabinet Secretary for Health and Sport, Professor Leitch and Mr Foggo for their evidence. It has been a wide-ranging and helpful discussion. That concludes the public part of the meeting.

12:01

Meeting continued in private until 12:22.

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