OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 30 June 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 30 June 2022

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COVID-19 RECOVERY COMMITTEE
18th Meeting 2022, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Linda Bauld (Scottish Government)
Professor Jason Leitch (Scottish Government)
Dr Audrey MacDougall (Scottish Government)
Maree Todd (Minister for Public Health, Women's Health and Sport)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 30 June 2022

[The Convener opened the meeting at 09:30]

Communication of Public Health Information Inquiry

The Convener (Siobhian Brown): Good morning and welcome to the 18th meeting in 2022 of the COVID-19 Recovery Committee. This morning, we will conclude our evidence taking on the inquiry into communication of public health information on Covid-19. I welcome to the meeting Maree Todd, the Minister for Public Health, Women's Health and Sport; Professor Jason Leitch, the national clinical director; Professor Linda Bauld, the chief social policy adviser; and Dr Audrey MacDougall, who is the chief social researcher. Welcome, everybody. Minister, would you like to make short opening remarks before we move to questions?

Maree Todd (Minister for Public Health, Women's Health and Sport): Certainly. Thank you for the opportunity to discuss the Scottish Government's communication of public health information.

Communication was at the heart of our response to the pandemic. Our overarching communication aims were to reach the entire population of Scotland as many times as possible in the most cost-effective way, with accessible information that was easily understood and which motivated people to stay safe and to protect others. The challenges were significant, in that the situation was changing constantly. Information was often complex and sensitive, and there were risks around overload and confusion, particularly when the measures and messaging were different from those of the United Kingdom Government.

Behavioural science was, and continues to be, central to our approach to all pandemic-related communications activity. Alongside the significant behavioural asks that were identified by medical and other experts, our understanding of the factors that inform behaviour change among the population has been essential in delivering effective public health messaging.

As well as drawing on behavioural science best practice, we undertook our own research to strengthen our insights and understanding. Specifically, we sought to understand people's attitudes, awareness and motivations related to Covid.

We also looked to identify barriers that people had to adopting important public health behaviours. We used that evidence to develop our messaging across a range of media channels to ensure that different audiences and population groups were reached.

I turn briefly to the work that we did to drive vaccine uptake as one specific example of how we targeted our messages to help us to achieve the public health goals. We have ensured that all our Covid-19 vaccination communications are suitable for everyone in Scotland, with tailored messages, where necessary, to reach specific groups. We have translated vaccine information into multiple languages and provided it in a range of formats on NHS Inform.

We also developed a culturally sensitive vaccine explainer video, which was informed by insights from organisations that represent various communities across government.

Equally important is that we worked, and continue to work, with health boards and other partners to encourage uptake, particularly where it is low in specific communities. Our approach is informed by the evidence, including Public Health Scotland's equality data, which gives a breakdown of vaccination uptake by ethnicity and by deprivation.

We have sought to build trust, and to remove barriers for people who might not otherwise take up the vaccination, through a range of outreach activity and partnerships with local authorities, and community and third sector organisations. The research that was published yesterday shows that people welcomed having a local and more flexible service when they were considering vaccination.

Just as our approach to public communications was influenced by behavioural science and insight, our communications were informed by the science of the pandemic and how to fight Covid. That has meant that rapid access to the evidence and expertise across a range of disciplines and organisations has been vital throughout.

Just as the science behind our understanding of the pandemic constantly evolved, so too did our approach to how we commissioned and considered scientific advice. For example, we established the Covid-19 advisory group and sub-groups, which have brought together experts from a range of disciplines and organisations, including universities, Public Health Scotland, National Services Scotland and Scottish Government advisers.

The chief medical officer and the chief scientific adviser for Scotland also led a new network of our science and evidence-related chief advisers to share information across their specialisms. That has delivered a holistic approach to

commissioning and co-ordination of scientific evidence.

I look forward to this morning's discussion, and am happy to answer questions from the committee.

The Convener: Thank you very much, minister. I will turn to questions. We have about eight minutes each, this morning, so we will have to keep that in mind.

I come to where we are at the moment. We are aware that there are rising numbers: maybe one in 20 people in Scotland currently has Covid. Are there concerns about the latest spike and that it has happened early in the summer, which I do not think anyone was expecting? How is pressure on the NHS currently? I do not know whether that is for Professor Leitch or the minister.

Maree Todd: Professor Leitch will be able to give you more detail, but we are watching the numbers closely. The numbers are rising. That was expected, actually; it was not unexpected. We anticipate that we will face rising then waning numbers of cases of Covid for some years to come. My experts tell us that we are about halfway through the pandemic; we are not at the end of it, as some people might perceive. I will let Professor Jason Leitch give you much more detail.

Professor Jason Leitch (Scottish Government): Good morning, everybody. It is nice to be back. I had thought that we were done, but here we are again. This about Covid recovery: I am on day 14 of recovering from Covid-19, so that seems appropriate. I am one of the people in the statistics.

We are concerned. This has come at us four or five months after the last variant. There is a pattern, and we have had four versions: the current one is a subvariant of omicron. It is still responding well to antivirals and to vaccines, and people are not becoming seriously unwell, but as the numbers rise, predictably—as this room knows better than pretty much every room in the country—that means that people are in hospital and eventually, unfortunately, vulnerable people, in particular, die. We have had 43 deaths in seven days and we have more than 1,000 people in hospital with a Covid diagnosis. Of course, that diagnosis is mixed in with other diagnoses, as we have talked about many times in committee, but Covid makes things worse.

As we look across Europe, we are hopeful that numbers will not peak at the level that we saw a few months ago when omicron first hit us. What has happened in Portugal and other countries suggests that, if the country has had a big omicron wave, perhaps it does not get quite such a big omicron four or five wave, but it is still difficult, and particularly so for people who are vulnerable.

Our advice remains pretty much the same, but you can tell that our tone has changed in the past few weeks. It is to stay off if you are sick—whether that is staying off college, work or school—and it is certainly about reintroducing, or thinking about, face coverings, hand washing, cleaning surfaces and all the antiviral activities. Of course, the key intervention remains vaccination: if you have not come for one, if you are due a booster, or if you think that you have missed one, we want to see you. Those are the key interventions. We are concerned, but we are not panicking.

The Convener: Thank you. My husband and my six-year-old currently have Covid. I have to say that I tested my six-year-old at the weekend only because my husband was so bad. She was feeling totally fine, but she tested positive so I had to keep her off school. I was a bit confused about whether she should go to school or not go to school. After the restrictions of the past two years, we are now in territory where, with rising numbers, there has to be guidance that is quite clear, as it evolves.

Professor Leitch: I agree that the situation is more complex now because we are treating your six-year-old as if she had flu or norovirus and we are giving you quite a lot of the responsibility to manage that. You are very informed: you chair the COVID-19 Recovery Committee, so if you do not know what the guidance is, that makes things more difficult.

Let me be really clear. Our guidance is that your six-year-old does not need to be tested. Testing is optional; you can absolutely not test, but children who are sick should not go to school. They should stay off school, and your husband should stay off work, as far as that is humanly possible, until he feels better. Our guidance, in the round, is that there should be five days of full isolation. That is not a rule: nobody will come and check up on you or arrest you if you do not do that, but our rough guidance now, based on everything that we know about the disease, is that there should be five days of full isolation. That gives us a sweet spot in respect of spread versus society reopening.

The Convener: That is brilliant. Thank you. This inquiry is primarily about misinformation and disinformation. I will distinguish between the two: misinformation is consumed and spread inadvertently and disinformation is in some way deliberate. I know that some countries are recognising that tackling what happens in online media and in fake news has become a new warfare. For example, back in 2019 Finland appointed a Government ambassador, with the specific role of protecting against attacks on social cohesion and public trust. Does the Scottish Government think that an independent fact-checking service, as has been suggested by the

Royal Society of Edinburgh, should be established in Scotland?

Maree Todd: I will let Professor Linda Bauld answer that.

Professor Linda Bauld (Scottish Government): Just so that you are aware of it, I note that I participated in the Royal Society of Edinburgh's data and evidence sub-group.

That is an important question; it is absolutely essential that we tackle misinformation. A wide variety of organisations have a role to play in that. I know that you have heard in the committee from Full Fact, which plays an important role. It is not funded by the UK Government, but it is a UK organisation. It cannot tailor all of what it does to the devolved nations, but it has an important role to play. I think that we need to do what is suggested, but I would not say that we necessarily need to ask the Scottish Government to fund a new body. It would be worth thinking about what the correct model is and looking at international examples.

At the moment, I will say that we have done phenomenally well in Scotland in addressing misinformation. We have had support from UK colleagues and we have the Covid vaccine security group, which looks at online hate and misinformation. I, and Professor Leitch and others, have engaged with it. It has played an important role.

There is a wide network of others outside Government, including MSPs who are playing their part in responding to constituents' queries and making sure that people have the right information. I would not jump to say that Government should fund a new body. I would ask where the gaps are and what would be best model for Scotland.

The Convener: Thank you very much.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, minister and colleagues. There are a couple of issues that I would like to pursue.

Minister, at the start you talked about information here being easy to understand; I think that that was true of parts, but there were other parts with which we struggled. The Scottish Government early in the pandemic produced the FACTS acronym. I know that Jason Leitch will know what FACTS stands for, but I do not know many other people who do. Minister, do you know what FACTS stands for?

Maree Todd: I certainly do. Of course, I do; I am the public health minister.

Murdo Fraser: Right. What is it, then?

Maree Todd: FACTS is: F, wear a face covering; A, avoid crowded spaces; C, clean your hands; T, observe two-metre distancing; and S, self-isolate. [*Applause*.]

Murdo Fraser: Very good. I am very impressed. [*Laughter*.]

Maree Todd: I am lousy at acronyms, I have to admit. I find acronyms very hard. I can remember that acronym and I can remember the general meaning, but remembering what the individual instructions are is tricky. I agree that finding that sweet spot of simple messaging is difficult. I know that in England they went for—

Murdo Fraser: "Hands, face, space".

Maree Todd: See—I did not remember that one, although "Hands, face, space" is a very simple three-word message that science would say is an easy thing for people to remember and to understand.

To be honest, though, with either of those, people would know that it meant that they had to do something. They might not remember the specific phrases, but we see even now, two and a half years into the pandemic, that people know and understand the non-pharmaceutical interventions that they can deploy to keep themselves and others safe, which the information was about. We now hear people talking about whether they should be wearing face coverings again. Everybody is washing and gelling their hands much more routinely than they did pre-pandemic and they know that keeping their distance is a way to keep themselves safe. People know that being outside is a way to keep themselves safe and they know that ventilation is helpful. Lots of people know the behaviours that they need to adopt to keep themselves safe, which I think is an important measure of the success of the information campaigns.

Professor Leitch: We have evaluated FACTS, as you would expect, and 83 per cent of people said that FACTS changed their behaviour. Remember the order in which the two campaigns came out: FACTS was first and "Hands, face, space" was second. "Hands, face, space" did run in Scotland; nobody stopped it running. It was on television and it was on posters; it added to what we already had.

09:45

Marketing people thought about stopping what we had been doing for a number of weeks and switching the whole population to a new campaign. The marketing experts who had that conversation thought that that would be counterproductive; they thought that it would make things worse rather than better. We gave our FACTS information to all four countries of the UK. Remember that Wales and Northern Ireland did

other things of their own. There were judgments to be made about the timing of whatever marketing interventions were used. Fundamentally, the messages all pushed the population in the same direction.

Murdo Fraser: I was going to ask you about what follow-up you have done, but you have already answered that question for me.

One of the other issues that we have looked at is trying to counter disinformation, which we were talking about earlier. To put that in context, we have all seen that the vaccination programme has been a great success—there is no doubt about it—but a segment of the population is still resistant to vaccination. When we see the segmentation, quite a lot of that is among particular ethnic minority groups. The Polish community is one example of a group that, for whatever reason, whether that be cultural reasons or something else, is resistant to taking up vaccination. Do you think that enough was done in terms of public health messaging to try to counter disinformation about the effect of vaccination?

Maree Todd: Again, I will let Linda Bauld say a little bit more about that. One of the challenges for Government is that countering disinformation can validate it. There are some suggestions that tackling it head on is more dangerous than leaving it to rumble on and finding your own way to reach the groups who are susceptible to that.

Our work on collecting ethnic data relating to vaccination and identifying uptake, including low uptake, in particular communities has enabled us to change course and to do different things for those communities. We had our general vaccine communication, which was targeted at the whole population, but we had specific ways of approaching and outreaching into those communities where uptake was low.

I will give an example of that. Last week, I met Gypsy Traveller community health workers. In many ways, the Gypsy Traveller community is either hard to reach or we make it difficult for them to engage with our healthcare system. Having those trusted members of their community helping to push public health messages is a much more successful way of reaching that community and ensuring that we engage them with healthy behaviours and those offers. That is far more successful than a media campaign, for example. I will let Linda Bauld say more.

Professor Bauld: I will briefly make three points. The first thing is that you need a multifaceted approach. Vaccine equity and gaps in uptake are an international phenomenon, as you know. In Scotland, we have done much better than most countries. I think that you were given some evidence on a *Eurosurveillance* journal article that showed that, among European countries, we were second to top after Iceland in terms of our uptake and reducing deaths in the over-60s.

However, there are gaps, and the multifaceted approach just does not work for Government in reaching those groups, minority ethnic communities and others who do not necessarily trust the state in the same way. You have to fund and support organisations to do that. It is a shame that you did not hear from BEMIS, which I think was going to give you evidence in one of your sessions. You would have heard a lot more evidence from it about that. Professor Leitch, of course, personally spoke to Young Scot and to many different community groups.

Professor Leitch: Whether they wanted that or not, frankly.

Professor Bauld: We would concede, of course, that it could have been perfect and better than it was, but a lot of effort was made.

We had a lot of data underpinning where the gaps were and we tried to use that data to inform approaches and who should be supported to reach out. I do not know whether Dr MacDougall wants to add anything to that.

Finally, for me, vaccination is not over; it is an evergreen offer. Vaccination is still available; vaccines can still go into people's arms. I have a lot of sympathy for the voices that say that we should keep talking about vaccination all the time so that we make sure that the message is not lost. Did you want to add anything, Audrey?

Dr Audrey MacDougall (Scottish Government): I will come in briefly. With the data that we collected on vaccinations and through our public polling data in which we looked at people's attitudes to issues such as vaccination, we were able to home in on where we thought there were particular issues or problems. We used that information to create new campaigns, to have people like Jason Leitch, Linda Bauld and so on to speak to different groups, and to provide funding for different bodies to work with those groups who were more reluctant to take up vaccination. Through monitoring the rates and through our polling, we were able to see whether our efforts were making a difference. We monitored that very closely; we were very conscious of that issue.

Alex Rowley (Mid Scotland and Fife) (Lab): I am 58 years old. I have had my first two vaccinations, then I had my booster. There is all this talk about whether over-50s will need to get a booster coming into winter. What is the Government's position? Someone in that age group might be wondering whether they are at risk coming into the winter.

Maree Todd: That is one of the challenges that we have faced throughout the pandemic. We rely on expert advice. For vaccines, we rely on the Joint Committee on Vaccination and Immunisation to give us advice on which groups should be targeted with vaccination. It can work only at a certain pace. People want to know now whether they will get a vaccine in the autumn. At the moment, the JCVI has not come out completely clearly. It has said that some of the population will be eligible, but it has not made a final statement on who will be eligible. The Scottish Government has largely followed JCVI advice, because it is absolutely the expert on vaccination and it will help us to make the most of the vaccination programme, which has been so transformative in this pandemic.

Professor Leitch: The minister is absolutely right. I will set out where we are. The JCVI has two steps. It provides interim advice, which helps us to plan on issues such as whether we will need 2 million doses or 25 million doses. Its interim advice is to get ready to vaccinate at least for the over-65s, everyone who is vulnerable over the age of 12, and all health and social care workers. We can add that group up, so we know how many vaccinators and how much vaccine we need in rough terms. That is what we are ready for. That is more than 2 million doses for Scotland. We are getting ready for that.

The second step is that, over the summer, the JCVI will look at vaccine waning, at variants and at what vaccines are available, because there will probably be a new variant vaccine by the autumn that we do not have currently. We could give you a vaccine today, but would it be better to wait to give you the variant vaccine? We just do not know; the science is not there yet. Over the summer, the JCVI has said that it will continue to consider the science and it will then give us definitive autumn advice.

My instinct—that is all it is; I do not have an inroad into the JCVI any more than anybody else—is that it will reduce the vaccination age in the autumn. I am 53, so you and I, Mr Rowley, will probably be in that group, which will be a bit more like the flu group. We do not know that for sure. That will depend on what happens to the disease and our response it; it will also depend on what happens to the virus between now and autumn. I think that the JCVI will move to a broader group in the next three or four months.

Alex Rowley: I think that I read that Professor Bauld had said that the Scottish Government should make representation on that and that it should be calling for all over-50s to be vaccinated.

Professor Bauld: There is always confusion with how the media uses a sentence that you have expressed, as everybody in this room will know. [*Laughter*.] [*Interruption*.] Yes, exactly.

I was very clear that my personal view is that, given that I had seen some data, for example, from the US looking at the response to people in their 50s from an additional booster, it would be likely that the JCVI would move in that direction, which is exactly what Professor Leitch has said. We do not know what the JCVI will conclude, but it would not surprise me if that is the decision that it takes. As Professor Leitch has said, having spoken to the vaccine team, it is preparing on the basis that that eligibility could be expanded. It knows that it can press go if more of us—I am in my 50s, too—are on that list. We wait to find out.

Maree Todd: Can you believe that even I will possibly be eligible? [*Laughter*.]

Alex Rowley: That then brings me to this question. In the past couple of months, I have met trade unions in the public sector, I have met nurses and I have been at health centres. I have come away thinking about how all those people are run off their feet. This has been a difficult time, and if we as politicians think that, on the last business day before recess, we want a rest, those guys have to carry on working through.

When I read the comments that have been attributed to Professor Bauld, that makes me think about what would happen if we suddenly need to vaccinate the over-50s over a certain period. The previous time that that happened, I saw staff being pulled out of lots of parts of the national health service. I am not sure what damage that would do, given that we are focusing on recovery. Are we preparing a plan for that? How would we do that?

Maree Todd: We are preparing a plan for that. We have learned a great deal during the pandemic about how to do that in a way that does not impact on the rest of the NHS. Most NHS boards have built up vaccination teams and vaccination plans. Over the past year or two, given how vaccines are now being delivered, people are finding that different vaccines are being done at different rates and in different places. For example, people are getting their flu vaccine in a different way—that has moved largely out of general practices and into health board centres.

We are absolutely aware of the challenge for the teams on the ground. I am a pharmacist by profession. If I think back to the course of the pandemic, we did not even know what the virus was when we were hit by it. In a year, we had a vaccine. I looked at that vaccine and thought, “Oh, my goodness, it comes in a multidose vial. It needs to be reconstituted and—good grief!—it needs to be stored at minus 70 degrees. How on earth will we manage that logistically? How will we get that into people’s arms?”

That complexity has continued to evolve. We now have multiple different vaccines. We have different ages eligible, which brings in different doses. We have people in the community with different needs. For example, people with severe immunosuppression are getting more vaccines than the general population, because their immune response is suppressed.

There is massive complexity in the vaccination programme, but we have done an amazing job in Scotland in rising to each and every one of the challenges. I was in absolute awe. Last December, I remember when omicron hit and we thought—like Brenda in that famous clip—"Not another one!". It just seemed incredible that we were facing, in the depths of winter, when everybody was looking forward to Christmas together, yet another variant and that need to get boosted by the bells at new year. It was the most phenomenal effort and response from our NHS and our teams.

I volunteered at a vaccine centre during the previous winter. People came out of retirement to help. I did not go through the training to vaccinate; I was just helping out with managing crowds. Jason Leitch has been vaccinating. People from Public Health Scotland have come forward and joined and the vaccinating team. It is just remarkable how our health professionals have answered the call. It is also remarkable how our communities have answered the call, because vaccines do not work unless people get them into their arms.

If I think about the levels of vaccination that we have achieved in Scotland, it is absolutely incredible for a vaccine that is not mandatory and that has had to be delivered at pace in a changing environment for a brand-new virus. There is no doubt that we have learned a great deal from each and every challenge that we have faced throughout the pandemic.

Alex Rowley: We are prepared in a way that will not impact on other services in the NHS.

Professor Leitch: We are ready, but it is not a neutral act, Mr Rowley. Let us be clear: you cannot use people twice. We are able to vaccinate with whatever the JCVI tells us to, and we will be able to do that fast. That will be a temporary measure. One of the things in the mix here is that, if we can vaccinate against Covid at the same time as we vaccinate against flu, that makes it logistically so much easier for us, because we are already going to do the latter for over-55s, the vulnerable and whatever other groups it is. That would make things a little bit easier for the workforce.

We have a director of vaccination and we have leads on vaccination in all the health boards. They know what is coming, roughly, and they will be ready for that. Let us be clear: we do not have an entirely new workforce or the funding for an entirely new temporary three-month workforce that can then all go back to hospitality for example. That is clearly not how it works. However, we are as ready as we can be to vaccinate on a temporary basis, and we will do that on a rolling basis, probably at least once a year but maybe even twice a year.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Good morning, folks. I want to come back to Jason Leitch quickly, because I am slightly confused. The convener talked about her daughter being positive but not sick. Should she go to school or not?

Professor Leitch: She probably should not go to school, but she should not have been tested, according to the guidance—the test is entirely optional. You are allowed to test your child, convener—I am not suggesting that you do not test your child—and, now that you have that knowledge, I would probably keep that child off school for five days.

10:00

Jim Fairlie: If an adult has tested positive but has no effects, should they go to work?

Professor Leitch: No, they should not go to work. Again, someone might not necessarily have that knowledge. Remember that 30 per cent of people with this disease are entirely asymptomatic, so people probably will not have tested, unless they are a health and social care worker and are still testing regularly. The reason why we do that is to try to take the people who are positive out of the at-risk groups.

The present guidance is that people do not need to test, because tests are no longer free. Some people are being given tests and being asked to test. That includes health and social care workers and some other minority groups in particularly high-risk areas. In the main, however, people do not have to test. If someone chooses to test and gets a positive test, they should isolate for five days.

Jim Fairlie: I can imagine the analytical discussion that my wife and I will have about this when I get home.

I will go back to communication. The committee has heard that the Scottish Government's review of the advice to those on the highest-risk list has not convinced people on the list that they are now at lower risk. Last week, we heard from Dr Sally Witcher, and one thing that I think struck all of us was that feeling that people are being left behind. How do we make life more liveable for people? I

keep getting the wrong terminology. She was concerned about the fact that we use the word "vulnerable", and I am not quite sure how we manage that language. How do we get people like Dr Sally Witcher to feel that society is now safe for them?

Maree Todd: Jason Leitch will probably give you a fuller answer on that, but the sensitivity around the word "vulnerable" indicates just how difficult it is to choose the right words to communicate risk to a population with different levels of susceptibility.

Professor Leitch: It is difficult. I have watched that evidence, and it is challenging, and appropriately so, for those of us in the public health communication space and in decision making. Let me tell you how the process actually works—whether you think that it is right is a different question.

One of Scotland's top doctors, a man called Professor Iain McInnes, who works at the University of Glasgow, chairs a UK-wide independent advisory group whose basic exam question is to consider who is at most risk of the disease and, therefore, who should get the antiviral drugs. Antiviral drugs are not a neutral act—they have side effects and other things going on, so you cannot just give them out on the high street. Therefore, if you are going to use those drugs, you need to decide who you will give them to. It has to be those who will benefit from them the most, and that is a clinical decision, not a political one. That is rightly in the space of the senior clinicians across the UK who make those choices. It is a bit like the Joint Committee on Vaccination and Immunisation, who are the boffins for vaccination—Iain McInnes's group are the boffins for high risk.

The challenge is that that high-risk group has changed. Let me use my family as an illustration. Right at the beginning of the pandemic, my mum, who was 81 years old with chronic obstructive pulmonary disease but otherwise well, was in the high-risk group for sure. She was told to shield, because we thought that she was at risk of this respiratory virus. In June 2022, she is no longer in the clinically extremely vulnerable group, because we have learned so much about the disease and we know that her COPD does not put her at extra risk. She is not eligible for antivirals because of her pre-existing conditions, although she might be because of her age. It is difficult to communicate that to an individual to whom we have said, "You need to stay in the house and remove yourself from society, because we think that you might die of this." Now, two years later, we are saying, "No, it is fine, you can go back to the theatre and church—you can do whatever."

That communication has been tricky. We have tried to do it in two ways. Professor Bauld and I never turn down a media bid, so we have pretty much done every single offer that we have had to be on the television or the radio to get the information across. That is one way that we have done it. That has dried up a little, of course, as the world has moved on and as media bids move away. We have written as often and as clearly as possible to those groups, which has been difficult. People have not always accepted the position of Iain McInnes's group on the vulnerable group, but I have to rely on the expertise and clinical knowledge, and on the increasing and evolving science on who should get the drugs.

We have massive trials. One that I have talked about previously in this room is the PANORAMIC study, which takes big groups of people, gives them a drug, compares them to those who do not get it and watches the results. That is how we know that dexamethasone works in intensive care and that some of the more far-fetched drugs do not work. We continue to do that for groups with antiviral drugs, and it teaches us every single day.

Iain McInnes's group, with Scottish and UK-wide representation, decides who is in that vulnerable group. That is how it works.

Professor Bauld: Dr Witcher also made a different set of points about environments. I think that her view on that, which is shared by many, is that we need to change our environments across Scotland to reduce the risk of infection in a range of settings. That is a valid point and, of course, we are trying to do that. It cannot be done quickly. I will highlight a couple of developments that MSPs are aware of.

The Deputy First Minister has recently written about the ventilation short-life working group. Certainly, the advisory sub-groups that I chaired on schools and universities heard from that group and learned from it and took steps on adaptations in those settings. There is much more to do.

There is also the Covid safety signage scheme that is now being piloted.

Jim Fairlie: You have obviously read my notes.

Professor Bauld: No, I have not actually—my eyesight does not stretch that far.

Jim Fairlie: That is because you are in your 50s.

Professor Bauld: Exactly—that is true. That is a very good point. The reading glasses are in the bag.

Orkney Islands Council and others will be piloting that scheme, although it does not go as far as colleagues and Dr Witcher would like. We are

committed to longer-term adaptation, but it will not happen overnight.

I do not know whether you want to add to that, minister.

Maree Todd: No, it is fine.

Jim Fairlie: Dr Witcher has used the hashtag #InclusiveNewNormal. I presume that, as Professor Bauld has just outlined, it is about how we make public spaces such as theatres safer. Work is on-going, but it will take more time. Until that is done and people feel that it is done, they will feel forgotten about. There is not much that we can do about that until we move on, is there?

Maree Todd: I think that people should have confidence that that work is on-going. It cannot happen overnight, and nobody has a magic wand, but it is on-going. The thing to try to communicate is that we are in a very different place from where we were at the start of the pandemic, in that we have a really effective vaccine. I am a pharmacist. It is perhaps a little hard for people to understand that, despite the fact that the vaccine does not prevent transmission, it is really effective. It does not prevent you from catching the illness but it has taken away the death and serious illness. We are not seeing the level of hospitalisation that we had, and we are certainly not seeing the level of mortality that we had. The vaccine is incredibly effective and has transformed the situation.

The people who are not responding well to the vaccine are largely people whose immune systems do not make antibodies when they are vaccinated. That is why there is the evolution in the groups who are particularly at risk. It is why people who we thought were at risk pre-vaccine, such as people with COPD, are less likely to be in the high-risk groups now, because their immune systems work well. People's immune systems are less effective at 81 years old, but they are not immunosuppressed in the same way as people who have had organ transplants are, for example.

The other tool that we have in the box that has transformed things is antiviral medications. People who are eligible for those medications know who they are and how to get them. Wherever those people are in the country, they know that there is information on NHS Inform. They can find the phone number of their health board and telephone if they test positive. As long as they are in that eligible group and within the first five days of illness, they can get the antiviral drugs. Even for the people for whom we know the vaccine is less effective, we have treatments that can reduce the risks from the virus.

We are not in the same situation that we were in before, and none of us has forgotten about the people who are severely impacted. One challenge is communicating to that particular group how important it is for them to protect themselves and keep safe. Using words such as "vulnerable" makes people feel ill and vulnerable, but it had to be communicated in that way—there is a tension. When I used to work in mental health, I had to work hard with the patients whom I worked with to help them to understand that they were ill. Once they understood that they were ill, they were motivated to take their medication.

It is a good and healthy thing if we feel healthy, and the understanding that you are not healthy, or that you are at risk or vulnerable, has quite a profound impact on people. We find that people are struggling a little to recover from that feeling of vulnerability, which is perfectly understandable. I think that nearly all of us—every human being in Scotland—has felt more vulnerable, and it is hard to remind ourselves that the situation today is very different from the situation that we faced in March 2020.

Brian Whittle (South Scotland) (Con): Good morning, panel. I want to go back to the way in which things were communicated. The Government or Governments—certainly the UK Government—used the term "follow the science". Generally, there was a lot of comfort to be had for the general population that there was a reason why they were being asked to take such extreme measures to look after public health.

The term "follow the science" was well recognised as a good one. However, did we do enough to explain to people what it actually means? Of course, science is a moving picture. To give a simple example, early on in the pandemic, the First Minister and the Prime Minister stood up and said that there was no evidence that face masks would make any difference, until the science said that they did make a difference. The message about following the science is great, but did we do enough to explain what it actually meant?

Maree Todd: That is challenging. As a scientist, I have a real passion for that issue. I think that, generally in our population, we do not have a great understanding of science. Science is not black and white and does not tell you what is right and wrong, but it helps you to answer questions. It is a way of seeking a way forward. All that it does is inform your decision making rather than tell you in a black and white way what you have to do. There is still always judgment in science. The phrase "follow the evidence base" is slightly less catchy, but that might have helped people to understand that it might be a changing feast.

There are not many positives to come from the pandemic, which has been the most testing time for the whole population, but I think that we have seen a far greater understanding of science in our population, which will stand us in good stead. We

have seen a great deal of health literacy and risk assessment going on. People have gone to the Public Health Scotland website and found the data for their local area, which has informed their risk assessment of what they might need to do. I think that is a healthy and positive thing to come out of the pandemic.

As somebody who used to yell regularly at the television, I have seen a vast improvement in our scientific reporting and medical reporting. When I worked as a pharmacist, I used to regularly be frustrated by the way that significant clinical trials were communicated to the general population. We have seen that happen in a far better way. Journalists who are reporting on science and medicine have stepped up and done a pretty good job of communicating fairly complicated things to a population who generally are not scientists.

I do not know whether either of my colleagues wants to add anything.

10:15

Professor Bauld: It is difficult. We have the structures to take in the science and to inform policy decisions. We had the chief medical officer's advisory group and the Scientific Advisory Group for Emergencies, which had some of the same people on them. We had the sub-groups on nosocomial infection and testing as well as the two that I chaired. We had all those structures, but the problem is that the science is not always definitive.

I will give some specific examples that I think the committee has discussed already. In a previous meeting, one member raised the issue of pregnancy during the very early days of vaccines. Because pregnant women were not involved in the trials, there was a bit of confusion around that, and then more clarity. We did not know at the beginning as much as we do now about airborne transmission or asymptomatic transmission. You raised the issue of face coverings.

There was not always a single truth to communicate to policy makers. It became much easier, because we got huge amounts of research. Countries around the world threw resources at the research and it became easier. In the early months, to say that there was a single piece of science was tough.

Brian Whittle: That is my point, though. The phrase "follow the science" was a good message, but we did not communicate properly what it meant and that the science would continually evolve. We did not communicate that message to the general public, so what people thought was, "I need to do this. Oh, but now I need to do this." Should we have gone further and said, "Follow what the science currently says, but it will evolve as we learn more about the virus"?

Linda Bauld: Behaviourally, trying to communicate uncertainty is challenging. The Covid social study shows that, in Scotland, the trust in the communication was very high—higher than elsewhere in the UK. It will never be perfect, and you are right that communicating uncertainty is very challenging. Whether the approach was perfect or not, I do not know.

Professor Leitch: I completely agree. The science changed, sometimes literally during television interviews. For example, while I was on television, somebody would text me to say that there had been a study on pregnant women that found that the vaccine was safe.

I think that Linda Bauld and others have been exemplars of public communication at a level that we have never seen in our lifetimes, in trying to get that science over to people and saying, "This is today's science." We were literally doing the science in real time. Normally, we would have medical and scientific journals that we could consider over a few months and then think about giving the information to the public six months later, but we did not have that luxury. We had to do it in real time, and we tried. Whether you think that we did that well enough is a different question entirely.

Brian Whittle: There is no criticism whatsoever. It is easy to look back to 2020 but, if we had to go through it again, would we alter the approach?

Professor Leitch: The only thing that I would add is that it depends on where people get their information from. The information from mainstream public service broadcasters was good and was well presented. For example, Fergus Walsh is an obvious example of somebody who covered the trials really well. If people get their information from Twitter, frankly, they need to look elsewhere.

Brian Whittle: Indeed. There is one more thing that I was going to raise. It is something that I never thought I would be raising, but a constituent has brought this to my attention and it speaks to the communication. My constituent is a nurse of 26 years' experience, and she has raised the issue of VITT—I suppose that I will have to say out loud that that stands for vaccine-induced immune thrombocytopenia and thrombosis . Did I do that right?

Professor Leitch: Yes.

Brian Whittle: I have been practising that for about a week. I think that it is now acknowledged as a condition and the National Institute for Health and Care Excellence published clinical guidelines for it. Her absolute belief is that vaccination was absolutely the way to go. However, I was surprised to hear that there are about 220 confirmed cases, 78 fatalities, 69 probable cases

and 70 possible cases. She says that these are relatively very small numbers compared to the vaccine. Nonetheless, these are people who have a condition, who have reacted to delivery of multiple doses of vaccine in a relatively short time. There was inevitably going to be some medical and statistical harm done.

What she was saying is that these are people who have had an adverse reaction to the vaccine and were vilified, pushed away and not listened to at the time, and who have a clinical need. With regard to the issue of communication, her question is, did we communicate the very small potential risk that there was with the vaccine, and, by not doing that, did we create a vulnerability in those few people who had an adverse reaction?

Maree Todd: I am sure that Jason Leitch will want to say a little bit more about that but, with any vaccine programme or vaccination, there will be a balance of risks and benefits. We have seen that very clearly played out as the JCVI gathered together the evidence for vaccinating children, where it felt that the benefit-risk balance was a little bit different. You need to take into account which population you are aiming your vaccine at. For some people, it will be a complete no-brainer because they will be particularly at risk from the consequences of that virus. For others, it will be a question of considering their own vulnerability and how much it helps the population for them to be vaccinated. Those are not clear-cut decisions.

Vaccines always carry risks. It is always a very small number of people who suffer adverse side effects. It is often the case that you cannot predict who will suffer those adverse side effects. If you could predict it, you would be able to take measures to avoid it. With a vaccine programme of the scale of this vaccine programme, where you are targeting pretty much the entire population, there are likely to be some people who suffer adverse events, but the benefits on a population level still outweigh the risks. That is a really important thing to communicate.

One of the challenges is that there were some side effects that might have been more predictable and there were people who thought that they perhaps should not have the vaccine. There was a question around people with allergies or allergic responses to vaccines. If you have had anaphylaxis in the past, it is very frightening to accept a vaccine where there is potentially a risk of allergy. Communicating messages that would reassure those individuals in relation to an individual assessment of whether someone is at particular risk from this vaccine is difficult. We could not communicate that at population level; that had to involve an individual discussion between clinician and patient at the time of vaccination.

Brian Whittle: The question that I am really asking is around that communication. If we had communicated and discussed the potential risk more, would that have prevented more people getting—

Professor Leitch: No, quite the opposite. I disagree with your premise entirely.

Brian Whittle: It is not a premise; it is a question.

Professor Leitch: Okay. Well, the answer to your question is no. *The Lancet* has just published the first global study into vaccination and lives saved. It is not complete, because it cannot be complete. It suggests that 20 million lives have been saved in the past year. It is quite remarkable. We think that 18 million have died of the disease. Your biggest risk in relation to blood clots is Covid. The number of people who have had blood clots and die because of Covid is off-the-scale higher than those who have had blood clots because of vaccination.

We have also adjusted the vaccination programme in light of some side effects that developed. I do not recognise the numbers that you read out. They are certainly not Scottish numbers. However, those numbers would suggest that we should look at that issue, and we have. Every time there are large-scale side effects from vaccination, we move. You will remember that, right at the beginning, we adjusted Pfizer because we had some allergy issues. Later on, we had some young men with blood clots, so we adjusted which vaccine they got, the order in which they got them and when we were going to do them. We have moved along the line, along the road of vaccination, and changed it as we have gone.

Let us be very clear to the public. The thing that you can do to protect yourself from this disease, including the blood clots you get from this disease, is to get vaccinated.

Brian Whittle: I think that you have missed my point, Mr Leitch.

The Convener: We will have to move on to John Mason—sorry, but time is moving on.

John Mason (Glasgow Shettleston) (SNP): To follow the same theme, as you said, Professor Leitch, it is important where we get our information from and Twitter is not the most reliable source. However, there is quite a lot of discussion on Twitter and that 20 million figure has been very useful. I have been quoting it quite a lot myself.

You said that you disagreed with Brian Whittle about the numbers. Can you give us any figures for how many people have a serious reaction to the vaccines or experience side effects? I had a sore arm and I did not feel well for 24 hours, which is pretty common. However, people are quoting

this yellow card system and all sorts of things. You said the numbers for blood clots from Covid were "off-the-scale". Are there definite figures about how many people have either died from the vaccine directly or indirectly or had a serious injury?

Professor Leitch: Yes, there are; they are on the Medicines and Healthcare products Regulatory Agency website. I do not have them off the top of my head. I am happy to send you more details, but you will be able to find them yourself. The numbers are tiny. Of course, you then have to take into account the fundamental and unsatisfactory fact that you cannot always relate vaccine to outcome. Inevitably, when you vaccinate the whole world, some people have a stroke the next day and some people fall under a bus the next day, but neither event is related to the vaccine. When you vaccinate billions of people, you inevitably get people who, in time order, end up with whatever happens to them.

Of course, there are some known side effects of vaccines—sore arms, some allergy issues and some blood clots. That is absolutely true. We think that blood clots occur in tiny numbers and we think that, when we adjust the vaccine that we give, we can reduce that number even further, and that is what we have done.

John Mason: Looking forward, rather than back, and thinking about working with the MHRA and so on, are there things that we can do in the future? Science is moving on and, as I understand it, we produced the vaccines much quicker than we normally would. That might happen again in the future, but that, in itself, gave people a wee bit of a lack of confidence. Is that just inevitable or do you think that maybe we could do something better in the future?

Maree Todd: I think that it is inevitable that, in a global pandemic, people will feel a little bit frightened and lack confidence, frankly. The thing to communicate about how the vaccines were developed is that no stages in development were skipped. What happened was that Governments underwrote the development and took the risk out of it for drug companies so that the trials that are required—the different phases of clinical trials—happened simultaneously instead of one after the other. Normally, in drug development, those things take up to 10 years because an early trial is followed by a trial on humans and a trial for efficacy and so on, with those stages happening one after the other and an assessment being carried out between each stage to see whether the vaccine seems to work. Because we needed the vaccine so quickly, there was a high risk of putting a lot of money into something that would not work, which drug companies do not want to do. Therefore, the risk was largely underwritten by Governments and those trials were able to happen simultaneously. No steps were skipped, and it is really important that the population understands that.

On the yellow card surveillance, there are surveillance schemes all around the world. The yellow card surveillance scheme is the one that is run by the MHRA. Post-marketing surveillance is absolutely vital when any new drug is developed and used in a population, as it gives us information. As Jason Leitch says, it does not establish causality but we get information on a population-wide level of what things might happen when a new drug is used. When new drugs are launched into the population, every side effect is reported through the yellow card scheme. There are ways that individuals themselves can submit a yellow card report, or their medical team can do it—there are loads of routes into that. What happens is that you gather a huge amount of information. What we have seen is that that level of analysis of that information has happened at absolutely remarkable pace. Of course, this is happening all around the world. The whole world is being vaccinated and we are learning globally. From all of that global data, we are getting a good idea of how to use the vaccines safely and effectively in the population.

The example that Linda Bauld gave of the changing picture for pregnant women is a good example of understanding. Rarely are drugs tested in pregnant women, for obvious reasons, so, when new drugs are launched, it is difficult to say definitively that they are safe in pregnant women. However, the vaccines were used worldwide and millions of pregnant women have now had those vaccines. That data is collected and analysed and used to refine the offer and make it even safer and more effective as we go on. It is really remarkable. I hope that that level of global scientific collaboration continues beyond this particular emergency.

10:30

John Mason: I will move on to a slightly different subject. We have taken a bit of evidence about whom people trust for information. This relates particularly to the Polish community and other ethnic minorities being a bit reticent and, in some cases, their having received information from the Government of their home country, be it Poland, Africa, Pakistan or wherever.

I was interested in the paper that Public Health Scotland submitted, which says that the most trusted people are the NHS, Public Health Scotland, health professionals and the Government, which is encouraging. Less trusted sources include social media, community leaders, religious leaders and news media, which struck

me as interesting. I think that we had thought that if we could go to community leaders in some ethnic minority groups, they would be more trusted, but Public Health Scotland seems to be saying something different. Do you have any thoughts on who is trusted and who is not?

Professor Bauld: That was probably a blanket response; community leaders will have been a category in the survey. There is a lot of evidence, including from international studies about medicines and vaccine hesitancy, that community leaders from particular groups are trusted, whether they are from a faith community or are working with women in an area, for example. It is about who people know and trust. I would not assume that all community leaders are trustworthy, but there is a lot of literature to suggest that if you get to the right ones, they are the best people to pass on the message.

The other source of data is the Ipsos MORI veracity index, which probably chimes with some of what Public Health Scotland has found. That is to respond to the specific question.

Dr MacDougall: All the evidence that we have seen certainly supports the general evidence that PHS is putting forward. It is noticeable that there were very high levels of trust among the public for people in the health professions, for scientists and, indeed, for the Government. There is absolutely no doubt that that has changed from what was the case pre-pandemic. I do not think that we would necessarily, pre-pandemic, have seen quite that level of trust in the science profession, for example, because people would have been less aware of the role of scientists and what they do.

We have seen that rise in trust throughout the course of the pandemic and we have, encouragingly, seen trust in Government maintained at a very high level as well, as I said. In terms of general communication of messages, every time we polled we heard that people had a very high level of trust in the Government as a source of information, and of trust in the Government to do the right thing.

John Mason: This is my final question. The Royal Society of Edinburgh was here early on giving us advice. There were a few things that it was quite keen on. It certainly wanted more science education in order to get the whole population thinking more scientifically, and it suggested the idea of an independent fact-checking service. Are you positive about those suggestions?

Maree Todd: I think that Linda Bauld has already talked about the independent fact-checking service.

I would love it if children were more interested in science, and I think that we are seeing that. People are inspired by folk like Linda Bauld and Jason Leitch, who have been on our television screens—

Professor Leitch: That is not true.

Maree Todd: They have been on our television screens for so long helping to guide us through this challenging time. I think that there is definitely more interest in science among the population, and among the young population.

I would be delighted if an outcome of the pandemic were to be that more people were to go into science disciplines. There are lots of them, so that would be a great thing. There are very few of us in politics with science degrees, for example, which I know has been mentioned many times since I came into politics. There are just a handful of the 129 MPs who have science backgrounds. It would be useful if more people had such understanding, rigour, and the ability to analyse information and put it together to be able to cope with grey areas. To be able to make good decisions despite uncertainty and gaps is absolutely a useful skill in government, so let us have more science, please.

John Mason: Thanks very much, minister. We have the message: more scientists—fewer lawyers and accountants.

Maree Todd: I think that Dr Audrey MacDougall, as our superb data scientist, is keen to contribute, as well.

Dr MacDougall: I just want to make a quick point about something that I have found to be really encouraging. Over the course of the pandemic we had, as you might imagine, a lot of correspondence from the general public—an enormous amount. My team, which has been collating science evidence and data, had a huge amount of people engage with us to discuss the science and the evidence. People were emailing us and asking us to look at calculations that they had done and to ask whether they looked right and how they might fit with what other people have done. The situation is a microcosm, but it has never happened before that we have had so many members of the general public getting in touch to discuss the science and the evidence, and to try to work it out for themselves. I found that to be immensely encouraging. It made me think that there is a real hunger among the population to engage and to be able to do that. I feel very positive about that, going forward.

Maree Todd: You have just reminded me that I should mention www.travellingtabby.com, which was absolutely outstanding citizen science, was it not?

Dr MacDougall: Yes, absolutely.

Maree Todd: Not all sites on social media are worth looking at, but travellingtabby.com was absolutely brilliant at analysing the data and presenting it in a way that was understandable to the population. It was remarkable work by a university student, who has rightly been lauded for it. More of that would be great.

The Convener: Thank you very much. I am conscious of the time; we have gone slightly over. That concludes our consideration of the agenda item and our time with the minister. I thank the minister and her supporting officials for their attendance this morning. I briefly suspend the meeting to allow the witnesses to leave.

10:36

Meeting suspended.

10:38

On resuming—

Subordinate Legislation

Coronavirus (Scotland) (No 2) Act 2020 (Suspension: Termination of Student Residential Tenancy) Regulations 2022 (SSI 2022/192)

The Convener: The second agenda item is subordinate legislation—consideration of the negative instrument that is listed on the agenda. No motion to annul the instrument has been lodged. Does any member have comments to make on the instrument?

Members *indicated disagreement.*

The Convener: Are members, therefore, content to agree that we have no recommendations to make on the instrument?

Members *indicated agreement.*

The Convener: Thank you. We agree not to make any recommendations on the instrument. That concludes our consideration of the item.

This is our last meeting before the summer recess. The committee's next meeting will be on Thursday 8 September 2022. That concludes the public part of our meeting.

10:39

Meeting continued in private until 11:07.

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