OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 23 June 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 23 June 2022

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COVID-19 RECOVERY COMMITTEE
17th 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:

Gillian McElroy (Health and Social Care Alliance Scotland)
Professor Jill Pell (University of Glasgow)
Adam Stachura (Age Scotland)
Dr Sally Witcher OBE

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 23 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 17th meeting of the COVID-19 Recovery Committee in 2022. This morning, we continue our inquiry into the communication of Covid-19 public health information. Unfortunately, Danny Boyle from BEMIS has had to offer his apologies. Murdo Fraser is running slightly late, but should be with us within 10 minutes.

I welcome Adam Stachura, head of policy and communications at Age Scotland; Gillian McElroy, policy and information officer at Health and Social Care Alliance Scotland; Dr Sally Witcher OBE, chair of the Scottish Commission on Social Security; and Professor Jill Pell, director of the institute of health and wellbeing at the University of Glasgow. Thank you for giving us your time this morning and for all your written submissions.

Our inquiry has three aims, and this evidence session is focused on the second aim, which is to consider whether public health information about Covid-19 is accessible to and meets the needs of specific audiences, including people in the shielding category and communities where there has been below average take-up of vaccination.

This evidence session will be the final stakeholder evidence session before we hear from the Minister for Public Health, Women’s Health and Sport on 30 June. We estimate that today’s session will run until 11 o’clock, and each member will have approximately 14 minutes to speak to the panel and ask questions. If you would like to respond to any issue being discussed, press R in the chat box, and we will try to bring you in. I am keen to ensure that everybody gets an opportunity to speak, but if time runs on too much, I may have to interrupt members and witnesses in the interests of brevity, so I apologise for that in advance.

Just to clarify, Dr Sally Witcher is attending in a personal capacity.

I invite witnesses to briefly introduce themselves.

Adam Stachura (Age Scotland): Good morning. I am the head of policy and communications at Age Scotland, which is the national charity for people over the age of 50. At the start of the pandemic, our national helpline became a central national resource for older people to understand the messaging around Covid-19, and we were funded by the Scottish Government to scale that up. We have had tens of thousands of calls from older people about Covid-19 and related measures since then, and I hope that we have lots of helpful information for the committee.

Gillian McElroy (Health and Social Care Alliance Scotland): Good morning and thank you for the invitation to give evidence to the committee. I am the policy and information officer at Health and Social Care Alliance Scotland, which is the national third sector intermediary for a range of health and social care organisations. We have a growing membership of more than 3,000 national and local third sector organisations. We have heard from our members throughout the pandemic that communication of public health messaging has been limited and interrupted at all levels, and we look forward to exploring that further in this evidence session.

Dr Sally Witcher OBE: Good morning. I first need to make absolutely clear that I am not here in the capacity of chair of the Scottish Commission on Social Security. I resigned from that role a few weeks ago, precisely because I was concerned that there may be confusion about what I say in a personal capacity on this matter and the important role of the commission. I hope that we are clear that I am here in a personal capacity as somebody with a 30-plus-year track record of working in the equality, inclusion and human rights fields in senior roles. I am a former chief executive officer of Inclusion Scotland and a former director of the Child Poverty Action Group. I have worked in academia and as a senior civil servant, and I hold various public appointments.

I am also somebody who was on the highest-risk list until it was discontinued recently. I am at prime risk myself. I am not eligible for vaccine boosters or antivirals. My last booster was eight months ago. I have been, basically, in my house for two-and-a-half years without any prospect of leaving in the foreseeable future.

I have a lot to say on behalf of people who feel that they are not being heard—as do an awful lot of other people out there, which I know from having been active on Twitter. There is frustration and anger about the fact that, although the tools exist to build a safe and inclusive new normal, they are not being used. It is not necessary for things to be this way.

The Convener: Thank you, Dr Witcher, and apologies for misrepresenting the capacity in which you are appearing. That was my fault—I was going by the briefing that I had. We acknowledge that you are here in your personal capacity.

Professor Jill Pell (University of Glasgow): Good morning. I am a professor of public health. I was a member of the Scottish Government's advisory committee on Covid until it was disbanded, but my reason for being here today is that I led a study on the shielding strategy, which looked specifically at whether it was effective in terms of protecting individuals and also at whether it had a role to play in terms of protecting health service demand.

The Convener: That is great. Thank you. We will now move to questions.

Some of the concerns that are raised in the written submissions by Dr Witcher and the Health and Social Care Alliance Scotland in relation to clinically vulnerable people. I think that it is concerning that, after what we have all faced over the past two years, the clinically vulnerable groups, who have valid fears of Covid infection now feel that they could be faced with hostility from the general public in some places. I was alarmed by what I read about that.

Dr Witcher, in your view, what would an inclusive new normal look like?

Dr Witcher: Clearly, the debate around vaccination and masking has become pretty toxic. What I tried to do was to think about what could be done that does not actually require action from the general public. There is no magic bullet here. The vaccines are a game changer but not a game winner for all time, so we need to think more broadly than that. However, there are a number of things that could be done that would have a real impact.

We need to understand that what makes people vulnerable is not just clinical risk; it is to do with exposure as well, and there is a lot that we can do around that. The kinds of things that need to be seriously looked at—they are being looked at up to a point, but not seriously, in my view—are a clean air strategy and some work on water, which we take for granted. One of the positive things that came out of the pandemic and could be part of a build-back-better initiative is the technology around air filtration that removes viruses from the air: high-efficiency particulate air—HEPA—filters. There is also technology around sterilisation. All of that is new, but it is emerging. That is another area of scientific inquiry that I think that it is very important to give sufficient weight to.

On the clinical side, we need to make good use of the tools that we have available. A lot of us are confused about the fact that, although we have been told that the reason for discontinuing the highest-risk list is that we now have vaccination and antiviral treatments—which we do, and they are good—people with high underlying clinical risk are not eligible. Why is that? We know that vaccinations wane—we are not told anything about that—and we know that they do not always protect fully. So, there are things around even existing clinical policy that are very mysterious and raise a lot of questions. We would love to know who is going to get the autumn booster. The situation feels really desperate, as we have nothing to say that our underlying clinical risk has changed in any way.

That is part of the issue, but another area for improvement is around masks. We now understand about different kinds of masks and that they need to be fitted properly—we have FFP3 masks and so on. Something should be done to make them available, as they are actually quite expensive. It is things like that.

If we are going to have a Covid-safe signage scheme, with premises putting signs in their windows, that should be made legally enforceable in the way that has been done in Belgium. That could be part of environmental health standards.

A lot could be done around the law. People such as unpaid carers are increasingly getting tuned into the fact that they already have lots of rights. Under the Equality Act 2010, we have things such as reasonable adjustments, but the messaging that we got and are still getting from the chief medical officer is, "Why not have a little chat with your employer if you are a bit worried about going back to work?" Actually, the message should be, "You have rights and, if they are not respected, that is disability discrimination under the law."

There are also laws on hate crime and clean air and there are building regulations. Those laws are wide ranging, but nothing is being done to promote them. In some cases, we are going to need to update those laws and rethink those things. The meaning of "equality" has changed and we now have new equality groups and new drivers. We need a completely different mindset and that should be factored into the review of the outcomes in the national performance framework.

Basically, that is my case. We need to think much more widely. If we used all those tools as we could and should, we could build a safe and inclusive new normal. It is not about some people having freedom at other people's expense or some people being restricted so that other people can have freedom; it is about everybody being able to have maximum freedom and avoiding the risk to everybody of long Covid. That risk is simply not being communicated. It is not just about those who are at clinical risk; it is about everybody's risk, and the numbers there are rocketing. This is a real crisis that is going to have a big impact on the economy and education as well as on people's lives and children's life chances.

The Convener: I totally agree. As you said, for the past two years or so, there has been no guidebook anywhere across the world on how to deal with the pandemic or how we emerge into the new normal. It is interesting that you mention Belgium, because I think that we can learn a lot from how countries across the world are dealing with issues and emerging from Covid. As I said, there is no guidebook and there are lots of lessons to be learned. Are there any other countries that you feel are a bit more progressive that we could learn from and that are getting it right as they emerge from Covid?

Dr Witcher: You are absolutely right that people are dealing with the issues in very different ways. The situation is developing the whole time. The pandemic is not over; it is still evolving. We are now in a different stage, but we are not in recovery. Therefore, we need to look widely and learn where we can.

I will not give you chapter and verse on this, because I do not have the research to hand, and I want what I say to be evidence based, but I would be happy to get back to you with my thoughts and the research on that, because there is learning there. Even just from what you pick up in mainstream media, you can see that other countries have different challenges. They have different cultural attitudes, leadership, starting points and understanding about such viruses. Therefore, we perhaps need to be a little cautious when drawing direct comparisons, but I think that there is an enormous amount of learning out there that could be incredibly helpful.

We all want to build back better, and that absolutely includes the Scottish Government. It is about working together constructively to make that happen within the very real and multiple constraints that I know Governments experience.

09:45

The Convener: That is really interesting. I will open up the discussion and ask the other witnesses for their views on how the needs of high-risk individuals can be better communicated to the general public as we go on to the next stage of Covid.

Adam Stachura: Something has been interesting in all of this, over the past two and a half years. At a certain point, we could have segmented the public into those who need extra help and those who do not, which would take us to quite a dangerous place. I do not mean that people should not get all the support that they need. Once people feel that they have freedom, they might feel that someone else is stopping them from getting maximum freedom, as Dr Witcher has suggested. Part of that is about looking at how the communication addresses what everybody in our country needs, so that those who are at the highest clinical risk, or are unpaid carers, do not feel that they are in the wind, left behind as the world moves on and not getting the maximum support.

In a sense, there is then negative communication from people who feel that they need support, whether or not the clinical advice is that they might be okay now, broadly speaking. Individuals will have a different view on that, because they know their health and circumstances better than anyone. I know lots of older people who are still shielding, despite not necessarily being at clinical risk, because they are terrified of getting Covid—they want to make sure that they are as healthy as possible, and they do not want to pass it on to anyone in their life who might be at a high clinical risk.

Part of that communication is about trying to avoid a situation in which those who need support communicate negatively about their experiences and it becomes a case of haves and have-nots. It is important for the health service and the Scottish Government to make sure that folks get everything that they could possibly need, so we do not have that disparity of experience.

Gillian McElroy: We agree with many of the points that Dr Witcher and Adam Stachura have made, so I will build on that and add some broader considerations. The Health and Social Care Alliance Scotland speaks strongly for an approach that is based on equality and human rights. That includes empowering people to know that they have rights, to claim them and to know that they have accessible routes to remedy and redress if those rights are not respected, protected and fulfilled. Part of the broader communication needs to highlight that.

In that equality and human rights-based approach, public bodies need to carry out human rights and equality impact assessments at the earliest opportunity, in consultation with people with lived experience, to understand the intersectional impacts of the Covid pandemic and the potential impacts of decision making on people's everyday lives.

As you touched on, there is also a need for on-going research and investment to fully understand the impacts of Covid. We have heard from members that there is a lack of understanding of the risks of Covid infection and the scale and severity of long Covid. Efforts are needed to improve the understanding and knowledge of long Covid in the community.

Recently, we commissioned research on accessing social support for long Covid. One of the key themes from that research was public awareness around long Covid and the effect that it can have on people. That suggests that there is a need for a national communications campaign to educate the public on long Covid, and the effect that it can have on people, as part of the inclusive new normal.

On your question about how the needs of higher-risk individuals can be better communicated to the general public, that might involve moving away from the binary positions that our members have perceived in the public messaging about Covid—that is, before the restrictions versus after the restrictions or before lockdown versus after lockdown. That needs to change at all levels—in national and local public health messaging and in the media—to increase the public awareness of the risks of Covid and the impact that it can have on people, including unpaid carers.

The Convener: Thank you—that is really helpful. We move to questions from Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): I apologise to colleagues and witnesses for my late arrival, which was because my usual method of transport, train, was not available, and I was battling with Royal Highland Show traffic to get in.

I would like to ask about targeting of communications, because the committee has heard from previous witnesses that there is not a one-size-fits-all approach to public health messaging that meets everyone's needs. We segment the population—there are various minority groups, including older people, those in ethnic minorities and those in higher risk groups, for whom the messaging might need to be different from the messaging for the general population.

I will start with Adam Stachura. Do you think that Covid public health messaging has been adequately targeted at different groups? If not, what more needs to be done to try to fix that?

Adam Stachura: That is a good question. At the beginning of the pandemic, and the height of severity of the virus, the broad national messaging—the really simple stuff—was good. It was undertaken on channels that were accessible to the vast majority of people. Television broadcasting, and advertising campaigns, were particularly good, because the messaging was simple. That is really important. The messaging at the time was very simple.

What was interesting at the time in relation to older people in general—it was the experience of our national helpline—was that, although there was very simple messaging coming from the First Minister, the chief medical officer, the clinical directors and others, our national helpline would immediately get phone calls from people asking for further clarity on what it meant in their particular circumstances. For example, "I do X or Y. Can I do this?", "I care for someone. Can I do this?", or "I have been told to stay at home but my mother lives a couple of local authorities away. Can I still go there?" There was the realisation that people's lives are complex, and that although the simple messaging is important, it raises other issues. The communication and channels at the beginning were pretty good but, at the same time, there was no other news. The only game in town was Covid news, and what our national protections were, which made life very straightforward.

As soon as things started to change, and the language changed, folk encountered more difficulties. Let us consider older people in ethnic minorities, whose first language is not English, who were at home, without the support networks that they might have had—whether that is community clubs and groups or their own family—to help them better understand the messaging. The translation from English, in the best way possible, might not have been as available to them as it could have been. There is an on-going challenge with making sure that everybody understands what the messaging is.

Going back one step, though—I will not dwell on this too long—as soon as the messaging about Covid became a bit more complex, the scale of inquiries to our national helpline increased massively. It became much harder to work out what the messaging meant in particular circumstances. We estimate that half a million over-60s in Scotland do not use the internet. There are also a hell of a lot of people who are online who do not use it particularly well, in the sense that they are not the most competent at everything. If things are buried away on websites, it might be a harder task for many than you might think if you are very digitally native. As soon as you start burying information online on websites and saying, "You can just go to NHS Inform or wherever", you make it harder. You could do any number of investigations into the websites of general practitioner surgeries and find a variety in the quality of information. Home pages can be very cluttered, so that people are looking for information and finding bits all over the place.

When the message was simple, it was effective. As soon as we started to use more complex messaging, people found it a lot harder to understand what the messages were. As soon as we stopped investing massively in broadcast and non-digital means of communicating, it became harder for folk to really understand and know where to go to get the right advice and information.

Murdo Fraser: Thanks for that answer. I am sure that all the MSPs here are very familiar with the situation of being bombarded with queries from constituents asking, “In these circumstances, can I do X, Y and Z?” We were not equipped to answer those questions, and it was a difficult and time-consuming process for us to get answers.

Professor Pell: On targeting, at the beginning of the pandemic, 2 per cent of the population were categorised as clinically extremely vulnerable and told to shield. Another 27 per cent of the population were in the moderate-risk group and were just advised to be more diligent in following the general guidance. When we looked at the data, we found that people in the shielded group were at much higher risk, but despite shielding, they were still 18 times more likely to be hospitalised from Covid and 49 times more likely to die from it.

The moderate-risk group was also at much higher risk than the low-risk category of people; they were seven times more likely to end up in hospital from Covid and 26 times more likely to die from it, but that group did not get the same targeted message as the shielded group. The moderate-risk group was much larger in number, so it contributed to far more of the hospitalisations and deaths in the general population, so that is a group that we need to consider. That group was predominantly made up of people who happened to be over 70 years of age but did not have the same level of morbidity that was required to be in the shielding group.

Dr Witcher: The first thing to say is that of course it is important to have clearly segmented communication and to understand what questions people have and how to answer them in accessible ways. It is also important, though, to think about the fact that most people access the general public messaging, so it is also about how that lands.

One challenge around that is that messages that will land with one bunch of people in one way will land with another bunch in a different way. If somebody says, as the First Minister did when the mask mandate was removed, that they are confident that most people will continue to wear masks, and they remind people to protect the vulnerable, what people at the sharp end hear is, “We are not confident,” because it only takes one. Our freedom is contingent on other people having the good will to protect us, which is not about rights or equal citizenship.

There is something there about the fact that people mostly go with the general message. The second thing about targeting is that the Government did a rather good job of establishing a channel for people with high underlying clinical risk in the form of the chief medical officer’s letter, which the Government has now discontinued. That was an effective way to communicate with people, but the key thing is that if audiences are very diverse, you must have multiple communication channels, and they all need to be accessible.

The CMO’s letter was a good communication channel, because a lot of people could access it—not everybody, but a large proportion of the target audience—but it did not tell us things that we wanted to know. It is one thing to get the targeted communication channel right, but if you do not have the information and are not using the channel to communicate what people want to know, it misses the point. The point was not that we needed to be told where to go if we needed a bit of support with building our confidence and going back to normal; the point was that we were very anxious because we had not been getting the information that enabled us to feel safe.

The evidence about the reason for discontinuing the—[*Inaudible*.]—the higher-risk list was that it was inaccessible; out of date, which was clear from what it said; not robust and dealt only with the question of vaccine protection. There was nothing on waning vaccine protection or the whole manner of other things that people wanted to know. People wanted to know about Evusheld and autumn boosters.

10:00

A number of things are needed, such as getting the general comms right and making sure that they land correctly with everybody, and establishing good channels and making use of them in ways that will be effective and answer people’s questions.

Probably my biggest point is this. If you really want to reach segmented, specific groups to tell them what the need to know effectively, why not ask them and involve them in the development of communication strategies? They will tell you how communication will land and whether it answers their question.

The Government has done a lot on setting up little groups. There are policy panels, such as Inclusion Scotland’s panel on social care support and the core group for the social security charter. There are models out there. The Government could that model; I do not know why it has not.

Communication goes two ways. It is not just about saying, “We tell you what we know, what we don’t know and what you should do,” but about saying, “What do you need to know? What are your questions? What are your concerns? Then we'll tell you what we know and what our advice would be."

The top-down, adult-to-child model—Government as parent—is not going to work. People are not children; they are adults. Whatever their views about the situation, they are not stupid. They can spot mixed messages a mile off. They can work that out if they are told that they have to keep 1m distance in one setting but 2m in another and that, in yet another, it does not matter at all, or that they can have only three people in one situation but that it is perfectly fine to bring loads of people to another.

It is not just about targeting, but about making things consistent and clear. People are very diverse and are in very diverse situations, even within one segmented audience. Communication has to be consistent. It has to land right.

Murdo Fraser: Thanks very much. We hear you loud and clear, Dr Witcher.

Gillian McElroy: I want to add a few points from the perspective of the alliance, which will echo and chime with many of the points that have gone before.

Alliance members have shared that the public health messaging has been variable at both national and local levels throughout the pandemic. Although there have been pockets of good practice and some people have found the Government's guidelines useful, many others have found the changing guidelines and availability of services quite difficult to follow. That can lead to confusion and a lack of clarity on the guidance. That has a direct impact on people's health, wellbeing and ability to access health and social services.

A key issue, which has been touched on, is the lack of person-centred information. People have reported receiving blanket information that can be too general and ambiguous and that does not consider the needs of different and specific population groups.

Accessibility of information is also key. There has been a lack of accessible and multiple formats for Covid information, such as alternative languages, community languages, Braille, easy-read format, and basic things such as large print. There needs to be a universal and inclusive approach to ensuring that people are fully informed on an equitable basis.

We have heard about specific information issues for autistic people. Often, written communication can be too ambiguous and can lack clarity on key information. A tailored and person-centred approach is needed, to increase the understanding of the kinds of restrictions that were going on during Covid and to enable people to access health and social care services and work through health and social care interactions.

The key takeaways and learnings for us are the need to make information publicly available in multiple formats, to have those multiple formats published on a timely basis—including, where possible, making them available at the same time as mainstream communication—and, as Dr Witcher mentioned, to involve relevant experts, including people with lived experience, at the earliest opportunity.

Murdo Fraser: I have one brief follow-up question, which is for Adam Stachura. One of the messages that the committee has had is that social media could be used more effectively when it comes to targeting particular audiences. However, you said that half a million over-60s do not have access to the internet. I am interested to get your perspective on how effective social media would be in reaching groups—in particular, older people. [*Interruption*.] We cannot hear you at the moment.

Adam Stachura: I will just take myself off mute.

That is another good question. Social media has a massively important part to play in a lot of this. However, a lot of people—not just older people—are not online. They might not be comfortable online, or they might not be online every minute of the day, as you and I might be, Mr Fraser, given that we have a mobile phone in our pocket and may be busy on Facebook or Twitter, for example. Social media has a good part to play, but it should not be the primary route.

As Dr Witcher has alluded to, there are segments within every group. That is hard—targeting is tricky. Not everybody is on a list somewhere. Social media is going to be important.

In a lot of the Covid messaging from the Scottish Government, the national health service and others, the use of social media was pretty good. When folks were getting the messages, those were simple, and the videos were accessible. Things were short enough and directed people to a lot of the right places. A lot of good things happened.

However, an overreliance on a digital primacy route—not just in a national crisis but when it comes to including all our residents and citizens in the right information—is not necessarily right. As I said, lots of people might be digitally connected but not that confident in social media, not trusting in it that much, or worried about the wrong news in it—so-called "fake news" or disinformation. People can be taken in by sources that feel credible but in reality are not—whether that is about the effectiveness of vaccines or other things. As a national charity, we tried to articulate and re-advertise what the NHS and the Scottish

Government were saying on all those things, as that was the most responsible thing to do.

Social media was important, but so were broadcast, newspapers and radio. Having British Sign Language interpreters on TV with the First Minister and others was a great thing, too. It was the right thing. However, in public health messaging, all those things are expensive. Social media is seen as the cheap, easy and quickest way. It might be, but getting it right is going to be intense and expensive. However, that is probably necessary.

Alex Rowley (Mid Scotland and Fife) (Lab): Good morning. I want to ask about the current situation. Right now, I know more people with Covid than I have done at any other point during the pandemic. The Covid numbers are increasing. This morning, I saw calls for all over-50s to be vaccinated.

Is there a greater understanding of Covid and the measures that are in place, or have people perhaps reached a point of thinking that it is a bit like the flu? Despite the fact that, across the world, other variants are starting to spread, are you relaxed with where we are at? Do you think that we need to have some kind of review to look at the messaging that needs to go out to support people in the here and now? Are you hearing concerns from your organisations about the current position? That question is for Adam Stachura in the first instance.

Adam Stachura: You have brought me in first, when I was hoping to ride on the coat-tails of others with my answer.

You mentioned restrictions but, for most people, there are no real restrictions. The general view is that we are sort of back to normality, because the measures that we were mandated or asked to take in order to protect ourselves and others have largely gone. The masks were the last element of that. Although there is an understanding that masks should be used, very few people of any age actually use them, even on public transport. A national vaccination programme is no longer in effect. The latest dose will be available to some people, but not to everybody. Therefore, the vast majority of folks will not think that it is necessary or for them. Things have moved on. Folks are going on holiday abroad again.

You are right about the number of people with Covid; I am aware of more people than ever who have had Covid recently or who have it now. The severity might be a lot less than it was two years ago, because we are hearing less about people being in hospital, so maybe folks feel that we are in a better place. However, at the same time, there are news stories about new variants.

Through our helpline, we now hear very little from older people about Covid-related issues. Instead, we hear about the challenges in relation to how they get life restarted and what they are facing in their lives, such as loneliness, isolation, mental and physical health issues, and lack of access to medical and health services and other social settings. For a lot of people, life has moved on, so they are trying to get back to what is normal for them, which is a lot harder than they thought it would be.

However, with new variants emerging, there is anxiety about what will happen next. How quickly can we turn things back on if we need to? Looking ahead, what might happen in the autumn, the winter and beyond will start to become more of a concern for people, as new variants develop. We do not know a lot about the future. Now that all the restrictions have been dropped, as a nation, are we ready and able to protect people as quickly and effectively as we have done in the past?

Gillian McElroy: Reflecting on your question, I think that there is a need for a better understanding of the continued risks of Covid to everyone. I touched on that earlier. Certainly among our members, there is a perception that the public messaging is very binary and that it is about before and after restrictions. I think that that needs to change, in order to increase public awareness. For many people, the view is that Covid is finished and over, but we know that that is not the case for huge numbers of people or for everyone. Therefore, we really need to think about that and to reflect it in our public messaging.

There is also somewhat confusing messaging. There is the Scottish Government's "Covid sense" campaign, but I am not sure how clear that is to people. Restrictions have, in effect, finished, but people are still being told to consider Covid sense. I am not sure how clear it is to the general public what that means for them, for people who are at high clinical risk or for unpaid carers. In answer to your question, there is still a need for awareness of the real risks of Covid as we continue today.

Dr Witcher: What is happening now is that we have hit crunch time, when the narrative that we are in recovery—that Covid is over and we are back to normal—has hit head-on the reality that it is not over. That reality is present in a lot of people's lives. As you rightly said, huge numbers of people are now getting infected, including people who are getting reinfected and people who have not been infected before.

10:15

What is happening here is like a screeching of brakes, because we need to do a U-turn from the messaging that we are being presented with that it is fine and we can move back to the old normal. There needs to be an acknowledgement that that is not the case.

People are understandably confused, because the messaging is mixed. I looked at it over a few days. On the one hand, a lot of experts are arguing that the entire population should be offered a booster; that long Covid is rising; that we have a new variant that is highly transmissible and which looks as though it might settle in the lungs, which could be more serious; and that herd immunity is probably a myth. Therefore, there are a lot of warnings. On the other hand, people are saying, “Oh, it’s mild. Compared to all the others, it’s not a problem. Very few people are now at clinical risk, because of the vaccine.” Although the vaccine’s power is waning, and we do not really know much about that, people are saying, “Hey, move on. Don’t panic—there’s no need for restrictions.”

I will issue a general plea. Can we please stop calling them restrictions? They are protections, not restrictions. They protect people’s freedom; they do not restrict it. That goes not just for people at high clinical risk, but for the population in general.

That is where we are now. I ask the Scottish Government to exercise some Covid sense, to respond and to follow the science about where we are. The Government should exercise some leadership by not causing us to spin over the edge of a cliff because we have not negotiated the change of tack that is required with the skill that we need to. If we do not get the messaging right and the Scottish Government does not get the policy right, we will be in a very serious situation.

If you think that people are disengaging and distrustful, perhaps that is because they are trying to make sense of the extremely mixed messages. I think that the Scottish Government has an important role to play. I still believe that it wants to do the right thing and wants to build back better. Murdo Fraser said earlier that I was being heard loud and clear, but I do not think a lot of people feel that they are being heard loud and clear. It would be brilliant if that could now happen, because there are a lot of very worried people out there.

Professor Pell: There are, in effect, four prongs to what we can do, and we have removed three of them. As Adam Stachura mentioned, we have taken away the non-pharmaceutical interventions, such as the requirement for social distancing and mandatory facial coverings. We have also removed access to mass testing—that needs to be acknowledged—and we have removed the idea of having a supported shielding list. Therefore, we are left solely with vaccination.

Vaccination reduces transmission and severity but, nonetheless, cases are going up, as Alex Rowley said. In some people, those cases will result in adverse outcomes, such as hospitalisation, death or long Covid. In addition, there is always the threat of new variants. We need to remain diligent; in particular, we need to think about whether we need to reconsider access to testing if the rise in cases justifies it. At the moment, it is very difficult for people, even if they want to be good citizens, to identify that they have infection and take action. We need to watch the situation closely and be willing to respond to it.

Alex Rowley: Some public health experts have called for everyone over 50 to get a booster as we come into winter this year. Professor Pell, is there enough information available to us? Do the public have confidence? By and large, vaccine take-up was good, despite some specific issues. However, I worry that the uptake of an over-50s booster would not be as high. What is your view on that?

Professor Pell: First, as I said, we are reliant on vaccination. We have removed the other options, so we absolutely must ensure that vaccination is delivered comprehensively and regularly with boosters. As you say, uptake has been good, but there has always been good confidence in vaccination among the Scottish population compared with the situation south of the border and in the United States. The Scottish Government has maintained that really well. If people understand—they have so far—and if you continue to communicate that, by getting vaccinated, they could potentially avoid lockdowns and further restrictions, that will motivate them to continue to get vaccinated, resulting in high uptake rates.

John Mason (Glasgow Shettleston) (SNP): We have talked a lot about communication, and I want to continue that with regard to the communication of uncertainty. We have had some advice from the scientific community that we should be very open about uncertainty, because that increases transparency and, therefore, trust. However, given that we have already accepted that getting simple messages across in all the different languages to all the different groups in society is quite difficult, I wonder whether that is realistic, when there is uncertainty, which there obviously is.

One example was the uncertainty at the beginning of the vaccination programme about whether pregnant women should be vaccinated. I think that the vaccine had not been tested on pregnant women and, therefore, a decision could not be made, so it was publicly said that that would have to wait. However, the message that many people took from that was, “Vaccines are dangerous for pregnant women.” Can you comment on how we deal with uncertainty? Perhaps Professor Pell could start.

Professor Pell: In Scotland, public trust has been much, much higher throughout the pandemic than it has been in some other countries. In part, that has been because the communication from the Scottish Government has been honest. It has been clearly explained to the public what we know and what we do not know, what we are doing and why we are doing it. When politicians and policy makers try to pretend that they know more than they do, people see completely through that and stop trusting you. Therefore, you should be open and honest with people—although not to the extent of scaremongering—because, that way, you gain much more trust and respect and, more importantly, much more compliance. People are much more likely to do what you ask them to do if they think that you are honest with them in your communication and if you justify why you are asking them to take certain actions. The evidence bears that out.

John Mason: You do not think that it increases confusion.

Professor Pell: No. Confusion comes from how you communicate. You can communicate uncertainty in a way that is clear or you can communicate it in a way that is unclear. The ability to communicate clearly must be separated from whether you are being open and honest.

John Mason: That is a good answer—I might quote you on that.

I turn to Gillian McElroy, because I think that the alliance talked about the fact that we need more communication around long Covid. Are we in the same place as we were with vaccination for pregnant women, in that there is so much uncertainty around long Covid that now might not be the time to be doing a communication campaign?

Gillian McElroy: There is a growing evidence base on long Covid, and the impact of long Covid is clear to those who have been affected. Therefore, we need to start communicating that now, because people have been severely impacted for the past two years. There is no reason to delay that, but I go back to the point about the importance of clear messaging.

John Mason: Is that the case even if we do not know and we are just being honest with people about that? Do you agree with the previous comment that, if we are uncertain about some things, we should just be honest with people about that?

Gillian McElroy: Evidence exists on the scale and severity of long Covid, and that evidence can be harnessed and communicated. I acknowledge that there are uncertainties, but we should start by communicating the evidence that we have in order to increase public understanding.

Dr Witcher: There is quite a lot of evidence on long Covid these days. We have seen figures that show that about 2 million people in the United Kingdom are affected, and the figures are increasing. I strongly advise that such figures should be included as a relevant indicator alongside hospitalisation and death rates, because long Covid is a growing problem. Employers and businesses are also picking up on it. In recent coverage, there has been some confusion about whether people who are living with long Covid are covered by the Equality Act 2010. I suspect that very many of them will be—it will depend on whether they are covered by the definition of a disabled person.

There is a lot to be done here. Long Covid is a new feature that is arising in this next phase of the pandemic. Organisations such as Long Covid Scotland and Long Covid Kids Scotland have a lot of data, information and lived experience to contribute. It is worth recognising that this is definitely happening now. The picture is evolving, as has been the case throughout the pandemic, but we have information. I agree with Professor Pell that we can be very clear in communicating that the situation is not yet clear, but we need to communicate that. We should also be very wary of communicating certainty when we are not certain.

However, some things relating to long Covid are pretty clear and we could communicate them now. The scale of risk and, in particular, the scale of reinfection are pretty clear. The issue is on-going; it is not a case of getting Covid once and then it is over and done with. There is no herd immunity. Each time someone gets Covid, there are risks of long-term and life-changing damage to their brain, their heart and all kinds of other organs.

John Mason: That is helpful. I think that all the witnesses have given a consistent message so far, which is good.

Dr Witcher, you have emphasised the use of words, and I fully accept that words are really important. However, I am a little wary about what you said about only using the word “protections” and not the word “restrictions”—it strikes me that they are both. If we were to only use “protections”, I wonder whether people would say, “You’re just putting a spin on it, because the reality is that my life is being restricted. I cannot go to visit my friends in London, for example.” My suggestion is, surely we should use both “protections” and “restrictions”, so that we are being honest with people.

In your written evidence, you also seem to be critical of the use of the word “vulnerable”. Could you expand on that? I am interested in that, because I have to say that we use that word in the Parliament quite a lot. We talk about people who are financially vulnerable, and we use the word in a health context and in a variety of other contexts. Could you comment on the use of words?

Dr Witcher: I would be delighted to. Thank you for the question.

Some forms of protection are restrictive. Lockdowns provide protection, but they very much restrict people's freedom. The challenge arises when we talk about things as "restrictions" when they do not really restrict freedom at all. In both cases, things are restrictive in as much as action is required, but they do not necessarily limit freedom at all. Limiting freedom, if that is what is needed, is done in order to protect; it is not done because we thoroughly enjoy restricting people's freedom.

We need to think about how communication is used and what is communicated. There is also an issue about where you are positioned. For us, we often consider what are portrayed as restrictions as being protections—not just for us but for other people. Communication is about how things are understood. We could say that calling things "restrictions" is putting a spin on it, too, subject to someone's agenda.

10:30

With regard to the word "vulnerable", it is not necessarily the case that you cannot use it. A lot of people who are at high clinical risk use that word themselves. For me, it is about understanding what creates vulnerability. I am arguing that being at high clinical risk is not necessarily what makes someone vulnerable. If you are in an environment that is safe, where the virus is not being allowed to let rip because the infection spread is being managed and protections are in place, you are not vulnerable. What makes a person vulnerable is not the fact that they are at high clinical risk, but the removal of protections, which means that they are not safe, or the failure to install protective measures, such as HEPA air filtration, in the first place.

John Mason: That is helpful. I think that we are more in agreement than I thought we were at the beginning.

I want to move on to another subject. In its submission, the alliance talked about the idea of the third sector filling the gap, so I wonder whether that was a complaint. Maybe Gillian McElroy and Adam Stachura could come in on that. Is not that the place for the third sector? The public sector is largely lumbering and bureaucratic, and there will always be gaps. I see the third sector as being very good at filling the gaps. Am I right? What is your thinking?

Gillian McElroy: At the outset of the pandemic, we heard from people whose social care packages were withdrawn or reduced with little or no notice. In such situations, the third sector stepped in to help people and provide them with support. The issue is really about public bodies and the Scottish Government working in partnership with the third sector organisations and community groups that provide that support.

I do not think that the role of the third sector is to fill the gap as such; it should be valued as an equal partner in delivery of care and support.

Adam Stachura: If we look back at the Covid response from the third sector, we can see that it was, and still is, able to adapt to fill a gap a lot more quickly than the public sector. It is not the case that there was already a gap; a new gap was created, because we needed to do certain things. Age Scotland has a national helpline that we had to scale up from being able to take 80 calls a day to being able to take 1,000 calls a day, because there was no other resource for older people at the time. We were supported well by the Scottish Government to do that.

Look at all the support that was provided for people who were put on shielding lists. A lot of that work was taken on by third sector organisations that were able to adapt at breakneck speed and to deliver what was required for a long period of time. They played a really important role, given that we are talking about trust and communication. Those organisations are trusted and have networks, audiences and clients whom they work with, and for, on a regular basis. It has been of benefit to have a third sector that has been able to support people incredibly well.

However, the position of organisations is precarious. Financially, many charities and third sector organisations have had a very difficult time throughout the pandemic, which we are still in. When they are relied on to undertake extraordinary tasks, they need to be resourced to do that quickly. The Scottish Government, the UK Government and others provided a lot of support, which demonstrates how important the third sector is in Scotland and why it needs to be supported to be resilient. We have required a resilient third sector as part of the current crisis. I hope that it is the only crisis that we will face, but I am sure that it will not be. We need a big network that is able to step in. However, the third sector has not been able to help everybody, because we have so many people in the country who are not on anyone's list.

John Mason: That is very helpful. Thank you.

Brian Whittle (South Scotland) (Con): Good morning. I want to wind back a little and ask about communication again. Especially early on, the information that we received evolved and changed. Obviously, I am not in a vulnerable category, but I sometimes found the information to be difficult to follow and I was not quite sure what I should do when I was in public, then eventually when I was not in public. Did that have a disproportionate impact on people in the most vulnerable categories? The impact of Covid on people who are clinically vulnerable is much greater so, potentially, the uncertainty about the information was much greater.

I want to get a bit of background on that; I will start with Professor Pell.

Professor Pell: I suspect that I am not the best person to answer that question—I think that Sally Witcher is better placed to do so. However, there are probably two issues. People in the high-risk group had to deal with two separate sets of communications—there was the general advice to everybody and the specific advice to them. They got a greater volume of information that was of greater complexity and, on top of that, there were people’s individual circumstances to consider. As we have heard, all information is, by definition, generic, and people need to think about how it relates to them personally.

It is probably better if I hand over to Sally Witcher to give the recipients’ view.

Dr Witcher: If you do not get the messaging right for people who are at the highest clinical risk, and for unpaid carers, the consequences for those groups are probably more acute than the consequences for any other group. If people do not have confidence, they will not go out, and they might be right not to do so. If people go out or follow advice that is not clear or that they have not understood, the consequences are very serious.

I have talked about us being, if you like, the canaries in the mine. If the information is wrong, we will bear the immediate brunt of that—we are the people who will signal that it is not right. Therefore, it is so important to get it right. As I said, it is becoming a wider issue because of the wider public risk around long Covid and the importance of getting the approach to that right, too.

However, if you do not get the information right for people who have exceptionally high underlying clinical risk, or for the people who are at less risk whom Professor Pell talked about, they will not know what to do. They do not have the information to gauge their own risk. It is all very well to say that it depends on how much the person wants to do something, but if they do not know what the risk is or cannot gauge it because the data does not exist, they will not know what to do. We cannot do a good risk assessment, and nor can GPs a lot of the time. That is the problem.

The issue is critical. Other people might be a bit unwell if the information is wrong, and some people might get long Covid, but it will be very much more severe for the likes of us.

Brian Whittle: The information evolved, so what was right at the start of the pandemic became wrong as our knowledge improved. Initially, a simple thing like wearing a mask was not proved to have an impact, then it was proved to have an impact. That was difficult for somebody like me, who is not in a vulnerable category, so how difficult was it for people who are clinically vulnerable to accept that kind of change? How could Government change its approach and what lessons can we learn to make the messaging clearer?

I am afraid that that question is for Dr Witcher again.

Dr Witcher: That is clearly a really easy question that I can answer in a few minutes. Ha! Or not.

The key thing is to get the basic communication right, which is to say that we are in an evolving situation and are learning. It is about communication of uncertainty, with clarity around that. People should not be given the message that Covid is over and then be told that it might not be over after all. Telling someone what our best understanding is for now is different from saying that no one needs to wear a mask. There is a lot of that going on.

It is important to talk to the people concerned and find out what their questions are. We should communicate the latest, and the right, information. The other big point that I want to get across is that communicating the wrong information—as in the distance aware scheme—will not do the business. It will not help. You must be clear about what people need to know. If you are not clear about that to start with, you are on to a loser, and it might not be the Government that is on to a loser but the people at the sharp end.

I appreciate that that was a quick answer. I would be happy to say more about that in writing, if you would like me to.

Brian Whittle: I was hoping that you would solve all our problems in a couple of minutes. [*Laughter*.]

Dr Witcher: Normally I would.

Brian Whittle: Gillian McElroy, it strikes me that that kind of evolving situation would create issues for the organisation that you look after.

Gillian McElroy: That goes back to trust, which we touched on previously—building trust in public health messaging. The starting point, as others have said, is to have high quality, accessible and inclusive communication at the outset. That is a key factor in communicating public health messages. The third sector has a role in communicating those messages and in helping to build trust with the people whom organisations support. Third sector and community groups have a key role to play in communicating trusted information. We saw that in the work to increase vaccination uptake in marginalised communities.

The alliance has community link workers in general practices. We know that they have been a key source of support and advice to people throughout the pandemic. They have well-established and trusting relationships. A wider suite of resources should be used to communicate public health messages.

Brian Whittle: We do not hear much nowadays about the continuing risk of Covid for certain elements of society. We talk about new normals and about going back to what we used to do before the pandemic, without recognising that some people in society are still at risk. What does the new normal really look like for those who are still at risk? Will we require a societal reaction to that? Should we all be asked to adjust our behaviour to protect those who are most at risk? Adam Stachura has been sitting there quietly for a while, so I turn to him first.

10:45

Adam Stachura: Thanks for the tough question, Mr Whittle.

In the early days of the pandemic, determining who was most at risk of developing severe ill health or dying as a result of Covid was strongly linked to age and various underlying health conditions, many of which come with age.

We know from our national helpline, from hundreds of older people’s groups across the country and from two a half years of input from over-50s, that older people were happy to take up multiple vaccines. There was anxiety among those people. When there were problems in administration of vaccines they became even more anxious because they had anticipated that vaccination was the way for them to live as they might have done before the pandemic.

On what the new normal looks like, we have folk who are still shielding, or are self-shielding because they are worried about the virus, but that means that they have not had access to medical treatment, so they might be in poor health. I know of that from a personal circumstance in which undiagnosed cancers led to a person’s early death. People are really worried about Covid itself, but the knock-on impact on their lives will be quite severe and we will be living with it for a long time. The new normal for them will be more of the same, but it will be hard.

We have the concept of building back better, but what does that mean? We are seeing a lot more flexible and hybrid working. We were bounced into that in a good way and had to adjust to it quickly. That will be a big positive for people. For people who have caring responsibilities, for example, the balance in their lives might now be better than it otherwise would have been.

What the new normal might look like for older people more generally will depend on what will happen in the future. We have, in recent days, had some dire warnings from the World Health Organization about what the future might look like with Covid and how it is a world-wide issue, and not one that we have to deal with only within the shores of the United Kingdom. It might come back in a more difficult variant, which might mean that we have to change how we live again. It has not gone away. Folk are anxious about that, but after two and a half years everybody wants to have as many as possible of the freedoms to live their lives as they did before, because it has been really tough going.

To go back to the point about communication, I note that it has been important to be able to give people enough good information from the right sources to enable them to understand where we are as a country. We demonstrated that we could communicate about new facts and about the situation changing. It was important that we were able to say that we had new information, what we were going to do about it and that we wanted people to understand the thinking behind it. Just saying that the clinical guidance is X and that, therefore, everyone must do X does not really cut it all the time.

We have spoken in the past about the proliferation of “Do not attempt resuscitation” forms landing on people’s mats early in the pandemic. They were not told that that was going to happen then, all of a sudden, they were being signed up to something about which they knew nothing. There was a lack of trust.

The future looks unpredictable. There is a lot of anxiety among older people about that.

Dr Witcher: Whether we like it or not, this is a new normal; it is not the old one. That means change. Some of the learning that we have acquired during the pandemic will be helpful in creating more inclusion rather than the opposite.

The question is how we build back better, although I have always preferred the phrase “build forward better” because I do not want to go back to the old normal, which was not great for disabled people and others. We need to use all the tools that we have had to do that.

That might necessitate some changes of behaviour, but not necessarily in bad ways. Using the positive learning about working from home or remotely can achieve a better work-life balance. It does not mean that people sit there doing nothing; it can be incredibly effective, because it cuts down on travel time. It also has implications for climate change.

There is also the hybrid approach—a real issue now is how we get better at hybrid events and so on. Again, that is still emerging. Clean air technology is also developing. We have to get away from the binary approach of thinking that it is about freedom versus restrictions and that we have to choose one or the other. It does not have to be that way.

Building forward better should mean focusing on what we—and everyone—can do in order to make the new normal inclusive and safe for everyone. So much could be done on that, but the point is that, if we are going to do it that way, we have to position that approach as the vision and the strategy. It needs to be wide ranging, and it will require cross-Government action. It is about not just health, but employment, education, hate crime, community safety and building regulations.

We need a comprehensive approach—in fact, a mixture of approaches. People need to accept that, in order to protect their own freedom, let alone that of everybody else, they are, on occasion, going to have to behave in certain ways. However, we also need to maximise and continue to develop the really positive learning about how we can create a fully inclusive new normal that is safe and that maximises everybody's freedom. That is what it looks like to me.

Professor Pell: As has already been said, it is important that we learn lessons, whether that is to deal with an uptick in Covid or another pandemic in the future.

If we look back at how the pandemic started and how it was managed at the beginning, we see that the approach in the UK, Europe and the US was very different in comparison with the approach in Asia. Asia had benefited, if you like, from SARS—severe acute respiratory syndrome—and countries were able to ramp up testing capacity early on, whereas we were totally reliant on non-pharmaceutical interventions and shielding. There are lessons to learn there.

Inevitably, we got some things wrong. For example, on care homes, we had staff moving freely between care homes and residents moving in and out of hospitals and so on. We need to learn from that so that we do not repeat the same mistakes. That is not about a witch hunt; it is about learning from the experience for the next time that it happens.

We need to accept that the new normal includes personal choices, and that we need to respect those where they do not impact on other people. Some people who were asked to shield chose personal freedom—they wanted to have a high-quality short life rather than a very restricted life, and that is entirely their choice if they are not putting other people at risk. Conversely, some people who are no longer on the shielding list may want to keep shielding. That might be due to real or perceived high risk, or concern about the pandemic, and we have to respect that in terms of how we interact with and behave towards people.

As we have said already, we need to incorporate vaccination against Covid, and boosters, as a normal part of living.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Thank you very much to the panel.

Dr Witcher, I will come to you first, although I know that you have been tasked with answering a lot of the questions so far. In your article in *The Herald* this morning, you talk about feeling that "vulnerable" people were "treated 'like lepers'"—that is the headline in the paper.

I absolutely get the feeling of, "It's okay, and everybody else is moving on, but what about us?" Is it your sense that those who are clinically at risk—I am trying not to use the word "vulnerable" because of your previous comments—are getting left behind?

Dr Witcher: Very much so, I am afraid. Just to be clear, I did not write that article—I would probably have written it a little bit differently, but the point stands.

I first made that point in connection with the distance aware scheme. We can think about how lepers were treated previously. I actually consulted the Bible for the first time ever, and it talked about people having to declare and identify themselves, and being isolated on the outskirts of town. They had to signal that they were infectious.

Now, with the distance aware scheme, the people who do not want to get infected have to distinguish themselves and to isolate, because there are no restrictions on going out for people who are infected. Frankly, some of those people have to go out, because they do not have support—they have to work. In reality, that means that now we are positioned as the odd ones out—we are the outcasts. I suppose that that has in some ways crystallised some of the feeling.

That is happening in the context of the revised strategic framework being very clear that we must not develop the approach in such a way that ends up, in effect, cutting off people who are at high clinical risk and other disadvantaged groups.

It is not just me who is saying this. In the Twitter thread that was part of the evidence, the responses communicate powerfully just how people feel about being abandoned—about not being communicated with and left behind. It is about seeing everybody move on and go back. As I said, there are also real worries about their safety in the current context.

The gap between where we are positioned and everybody else's position has become exacerbated. I have seen for myself that, if you start pointing out that there is a problem for people who are at high clinical risk and that the approach is not working for them, you risk attracting quite a lot of abuse and hostility—there have been examples of that. That again just underlines that you have no place in this society any more. The new normal does not accommodate you—you are not part of it. You are an irritating outlier. You are just one of the people who we ought to kind of remember.

So much of the messaging is saying, “Oh, and by the way, you ought to remember to protect the vulnerable—we ask people to remember to do that.” We are equal citizens. We have equal rights. We are active. The word “vulnerable” always conveys a sense of people who are passive, helpless and needy, but we are only like that because protections have been removed. We are not demanding lockdown. As soon as you start saying this, you get the response, “You are just telling us all to go back into lockdown.” No—the point is that we are telling people to do things so that nobody has to do that.

Jim Fairlie: That comfortably leads me on to where I wanted to go. I will give my general sense from today's evidence session. Right at the start of the pandemic, everybody got behind the Covid response—we all understood it, everybody was at risk and the message was simple. We started to change it, because things were moving and evolving. The message became more complicated, and it became more difficult to have that one-size-fits-all approach, so we tried to fragment it. Then we came into the later stages, where we got competing voices. The hospitality industry wanted things opened up. People wanted flights opened up. They wanted life to go back to normal and get their businesses moving. In among all that, people had fatigue and wanted to move on. However you, the clinically vulnerable—sorry; I am trying to get the right phrasing—

Dr Witcher: It is the highest risk.

Jim Fairlie: Yes. The highest-risk people are stuck. Is there a need for the general public to get a better understanding, through public health messaging and improving people's literacy and understanding of what we are trying to achieve, so that nobody has the feeling that everybody else has moved on but they are still in the same place?

Dr Witcher: I think that the big challenge is to communicate that, actually, we are all after the same thing. None of us is arguing for everybody locking down. It is not about some people having freedom or not. It is very much about making the business case.

You talked about the hospitality industry and the travel sector and hotels and so on wanting to open up. Of course they do, but the point now is that there are ways that they could do that and communicate that they are following good practice—they can install air filtration, for example—particularly if it was underlined with some legal back-up. As I started talking about at the beginning of the session, there could be a safety signage scheme of some kind that would communicate to people what has been done on Covid safety, so it is safe for them to go somewhere—or much safer—because measures are in place.

People in general go to restaurants expecting certain standards to be in place and for that to be inspected. There is a business case for that, because people will not go into places where they do not feel safe. It is the same with travel—if you do not feel safe, you are not going to travel.

11:00

That is the frustration. We are being positioned as if it is either this or that—there is this little group over here who are basically getting in the way of everybody getting on with their lives. Actually, that is not the case, because the sorts of things that we are asking for, which will be incredibly important to us, and without which there will be an incredible impact on us, are of much wider benefit. If you put in air filters, that will remove all kinds of viruses, as well as allergens and pollution. The general health benefit will be widespread. Maybe that is how to protect the NHS. It is about rethinking this fundamentally and trying to get out of the either/or mindset that we have got into, because that is really not where we are now.

Of course people have personal choice, and I completely respect that, except where their personal choice causes direct harm to others. Again, there are plenty of analogies out there, such as seat belts and so on. People are not told not to drive; they are told that they need to pass a driving test, wear seat belts and do certain things on the road.

Jim Fairlie: As Murdo Fraser said, you are being heard loud and clear.

The Convener: I think that all members would agree that the meeting has been really insightful and informative. I thank all the witnesses for their evidence and for giving us their time. If you would like to raise any further evidence with the committee, you can do so in writing; the clerks will be happy to liaise with you about how to do that.

At our next meeting, which will be on 30 June, we will take evidence from the Minister for Public Health, Women's Health and Sport on the inquiry into Covid-19 and the communication of public health information. We will also consider a negative instrument.

That concludes the public part of the meeting.

11:02

Meeting continued in private until 11:11.

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