OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 13 January 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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COVID-19 RECOVERY COMMITTEE
1st 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 Jason Leitch (Scottish Government)
Niamh O'Connor (Scottish Government)
John Swinney (Deputy First Minister and Cabinet Secretary for Covid Recovery)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

Virtual Meeting

Scottish Parliament

COVID-19 Recovery Committee

Thursday 13 January 2022

[The Convener opened the meeting at 09:00]

Ministerial Statement

The Convener (Siobhian Brown): Good morning, and welcome to the first meeting in 2022 of the COVID-19 Recovery Committee. This morning, we will take evidence from the Scottish Government on the latest ministerial statements on Covid-19. I welcome to the meeting John Swinney, Deputy First Minister and Cabinet Secretary for Covid Recovery; Professor Jason Leitch, national clinical director; Penelope Cooper, director of Covid co-ordination; and Niamh O'Connor, deputy director for testing and contact tracing policy. Thank you for your attendance this morning. I wish you all a happy new year, and I hope that you managed to have some sort of break over the festive period.

Deputy First Minister, do you wish to make any remarks before we move on to questions?

The Deputy First Minister and Cabinet Secretary for Covid Recovery (John Swinney): Good morning, convener. I am grateful to the committee for the opportunity to discuss a number of matters, including updates to Parliament on Covid-19, and to make some opening remarks before taking questions.

As the First Minister set out on Tuesday, although omicron is continuing to cause extremely high levels of new cases and we must remain careful, there are grounds for cautious optimism that our current additional measures and the efforts that are being made by people across Scotland are having an impact. Last month, our central projection was that new infections could reach 50,000 a day by early January. So far, that has not materialised, and we estimate that the total number of daily infections may be around 30,000. We are also seeing that the numbers of cases confirmed by a polymerase chain reaction test have fallen in all age groups, except the over-85s. That is encouraging, and it gives us some hope that cases might be at or close to the peak. Further, although the number of people in hospital with Covid has continued to increase over the past week, there are signs that the rate of increase may be starting to slow.

In line with our guidance that was set out last week, people without symptoms who test positive with a lateral flow test no longer need to secure a confirmatory PCR test. That means that the current daily numbers are capturing fewer positive cases than before. To address that, Public Health Scotland will, from today, augment its daily reports to include the combined figure for the number of people who have recorded a first positive PCR or lateral flow test. That additional data will allow us to assess the trend in cases more accurately. I encourage members of the public to continue to record their lateral flow results, whether they are positive or negative. That can be done very easily through the United Kingdom Government website, by searching for "report a lateral flow test".

Although we must remain careful and cautious, the Cabinet agreed on Tuesday to begin lifting the additional protective measures that were introduced before Christmas. We will do so in a phased manner, and further dates will be announced in due course. From Monday 17 January, the attendance limits on large-scale outdoor events will be removed. Certification will remain in place for events and venues that were previously covered by the scheme, and we are asking event organisers to check the certification status of more people attending events. From Monday, for the purposes of certification, the requirement to be fully vaccinated will include having a booster if the second dose was more than four months ago.

For the time being, baseline measures that were in place before the emergence of omicron, such as wearing face coverings in indoor places and working from home where possible, will remain in place. For the immediate period ahead, our advice remains that people should limit their contact with other households and, in particular, not meet indoors with more than three households. We are not asking people to cut all social interaction, but reducing contacts and prioritising who we meet will help to reduce the risk. Our advice remains to take a lateral flow test and report the result when meeting others.

Finally, the First Minister confirmed that the Scottish Government intends to publish a revised strategic framework in the next few weeks. I will update the committee further once that has been published.

I am happy to answer any questions that the committee may have.

The Convener: Thank you, Deputy First Minister. I will ask the first question. We are all cautiously thankful that omicron is not as severe as we first expected it to be when it emerged in early December. With the schools going back in the past week, I want to ask about the effect of omicron on our schoolchildren, especially as most of them have not been vaccinated. Can you update us on vaccinations for the five to 12-year-olds? Is ventilation in school settings adequate as the schools go back?

John Swinney: Obviously, we will carefully monitor the impact of schools returning. That is central to the approach that the Government is taking, because we recognise that their return marks a gathering of individuals within our society at a fairly high level. As we know, the meeting of individuals from multiple households leads to the spread of the Covid virus.

We will monitor the situation closely. That is why we are taking a phased approach to the relaxation of restrictions. Although the current data is encouraging, the data could be influenced by the effect of schools returning, and we will now only just be beginning to see the effects of that in the numbers, to the extent that that will have an effect.

We do not have authorisation from the Joint Committee on Vaccination and Immunisation for the widespread vaccination of children who are in the five-to-12 age group. The JCVI has not made the case for that and, as the committee will know, we look to and implement the advice of the JCVI. The JCVI has indicated that it is appropriate to vaccinate some children in that group, particularly if the child might be clinically vulnerable or living in a household with individuals who are clinically vulnerable. We are taking steps to implement those recommendations, as has been confirmed in Parliament.

On the final part of your question, ventilation is ostensibly a local authority priority. We have been engaging with local authorities on ventilation over the past 20 months, and we have required them to enhance the monitoring of air quality in schools to ensure that we have a good understanding of where some of the ventilation requirements might need to be in place. On Tuesday, the First Minister announced further expansion of the funding available to local authorities to enhance ventilation schemes, should that be required. Local authorities have undertaken extensive audits of ventilation requirements on a classroom-by-classroom basis, and we expect them to act accordingly to address any ventilation weaknesses that emerge out of those surveys.

The Convener: We know that the national health service is under a lot of pressure at the moment and, obviously, we knew that it would be. In light of some NHS boards calling in military help and declaring major incidents, can the cabinet secretary provide the committee with a rundown of the position of the other NHS boards?

John Swinney: There is a huge amount of pressure on NHS boards around the country. It would be fair to say that all boards are under intense pressure. They are having to manage high demand for services as well as difficulties caused by staff absences that have been caused by omicron. Obviously, the changes to testing arrangements and isolation periods that the Government has implemented will be beginning to have a welcome effect by easing some of those staffing pressures.

We are confident about the sustainability of NHS services at the moment, but the position is constantly dynamic. Individual hospitals will come under greater pressure as a consequence of incidents that take place and the demand that presents itself. We are issuing and circulating advice across the national health service to encourage people to use the appropriate health services for the circumstances that they face.

At this stage, the national health service is coping in all parts of the country, but it is coping under enormous pressure, and the headroom that is available to cope with increased demand is very limited. For that reason, along with the Cabinet Secretary for Health and Social Care and the Cabinet Secretary for Social Justice, Housing and Local Government, I have been leading dialogue with local government about expanding the capacity of social care services around the country. Obviously, the more we have effective social care services in place in the community, the more we can support individuals to have their needs met at home and in all other care settings in order to avoid their presenting at NHS facilities. That is one of the crucial interventions that we are making to try to stem demand and pressure on the NHS.

The Convener: Thank you, Deputy First Minister. Your update is appreciated. We will move on to other members.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, cabinet secretary and colleagues. I would like to ask about a couple of different issues, if there is time. I will start by raising an issue that I have raised previously, which relates to data. We have been trying to pursue the question of how many people who are admitted to hospital have Covid as the primary cause of their admission as opposed to its being secondary or coincidental. Some limited data that was based on two health boards was published on Friday by Public Health Scotland. When will we have a fuller picture, as that is really important for understanding the true impact of omicron on the health service?

The second issue relates to vaccinations. How many people who are in hospital and, in particular, in intensive care units because of Covid are vaccinated as opposed to unvaccinated?

Thirdly, are we aware of anyone having died as a result of the omicron variant?

I do not know whether the Scottish Government has that information, but it has not been shared with us or the public. I am interested to know whether that data is being collected.

John Swinney: I will draw in contributions from Professor Jason Leitch in relation to some of that material, but let me work my way through the points that Mr Fraser has raised.

On the reasons for individuals' hospitalisation and whether people are in hospital because of Covid or with Covid, data has been developed by Public Health Scotland, which has worked with data sets from NHS Greater Glasgow and Clyde and NHS Grampian. Those are two significant boards—NHS Greater Glasgow and Clyde is the largest board in the country, and it covers a substantial share of the population. We have to get into proper perspective the scale of the population that is covered by the data that was the subject of release last week, if my recollection is correct. That data gives us a fairly substantial picture of the country. It demonstrates the pattern that about 60 per cent of people who are being admitted to hospital in connection with Covid are admitted because of it. That is relatively similar to the numbers in the studies that have been produced in other nations in the UK.

The position is not too dissimilar to the position with earlier strains of the virus. If my recollection is correct, the data in the previous exercise that was published by Public Health Scotland showed that 68 per cent of people in the previous survey that was undertaken had been admitted to hospital because of Covid.

In the context of the volume of data that we publish on these questions, the data that has been published on that issue gives us a pretty good understanding of the balance and breakdown of that information, and Public Health Scotland will be working on further iterations of that data in due course.

09:15

The second point relates to vaccinated and unvaccinated individuals in hospital. From the latest data that I have seen, the analysis has shown that the unvaccinated hospitalisation rate was 59 out of 100,000, while the boosted hospitalisation rate was 15 out of 100,000. That means that the unvaccinated are four times more likely to be hospitalised than people who have had their booster or third dose.

I hope that that data helps, but I will draw in input from Professor Leitch, who will provide further detail on that.

Professor Jason Leitch (Scottish Government): Good morning, everybody, and happy new year.

Your questions are good ones, Mr Fraser. I will deal with them in order of simplicity and come to the harder one last.

The figures for the vaccination status of hospitalisations and deaths are published every week. I do not know why there is so much fuss about finding them. The figures were most recently published yesterday by Public Health Scotland. Mr Swinney has read out one of the elements: 59 per 100,000 versus 15 per 100,000. Mortality rates are included in the same publication. They were published the week before, and each publication shows the previous four weeks, divided into seven days.

Forgive the callous way of talking about mortality rates; I understand absolutely that these are real people with families who have had to grieve, even over the Christmas and new year period, because of this horrible disease. The unvaccinated mortality rate was 4.79 per 100,000; the boosted mortality rate was 0.21 per 100,000. That once again confirms—if we needed it confirmed—that the best protection that you can have is your booster dose. Those data are being replicated globally.

Bear in mind that, if you look at just the raw number of deaths, you may come to a different conclusion, but that is because the vast majority of people in the country are boosted. You have to age-adjust and look at the rates in order to understand the difference that the booster is making. Those numbers vary a little bit from week to week, as they are quite low.

I am afraid that your key question about whether people are dying of omicron or not is not a straightforward one to answer. More than 92 per cent of positive cases are now omicron cases, so we have no reason to believe that there is a continuing big delta wave, but we probably still have some stragglers coming through the system who will have delta. It is not absolutely certain that the deaths are from omicron, but I anticipate—as the rest of the research community does—that omicron does lead to some deaths, particularly among the unvaccinated.

We are learning more and more about risk. As I think I have said to the committee before, we now know that the principal risk is immunity. Whether someone's immunity is hampered by disease, a transplant, HIV—or something going on with your leukaemia—those are now the big risk factors, as is age. As you age, your immunity diminishes and that is why vaccination is such a big solution.

The intensive care data is harder to get than the hospitalisation data and the death data, just because of the nature of data collection and the small numbers of people who end up in intensive care. We rely on a slightly different mechanism, which is called the Scottish intensive care society audit group. It is about to publish its most recent data—I think that that will be in the next two weeks. According to the last audit that it did,

people were six times less likely to be in intensive care if they were vaccinated. That is the headline: you are six times less likely to be in intensive care if you are vaccinated. SICSAG will now redo that data for boosters and for omicron, and I look forward to seeing its conclusion. The global data says that going into intensive care is around six times less likely.

I turn now to your slightly harder point about whether someone is admitted to hospital with Covid or because of Covid. We have covered that before, and Mr Swinney has covered it. I do not know what the fascination with that data is. You have all the data that we have, and we have published everything that I have got around that question. It speaks, if you will forgive me, to a slight misunderstanding of how healthcare works. Healthcare is not about a single disease. The people in hospital with Covid who are in trouble do not just have Covid; they have diabetes, they have leukaemia, they are 87—they have all kinds of things going on. The death certificates often have five reasons for death, not one. Principal diagnosis versus secondary diagnosis will be a matter of judgment at time of death by the junior doctor filling in the death certificate.

By all means, you can get all the data that we have—and you have it, I promise—but I am not so convinced that that data is as important as some people perhaps think. Healthcare is not linear; there are very few people in hospital because they are having their leg fixed after falling over on the ice who then get a positive Covid test. There will be some, of course, but the vast majority of people getting care in our hospitals with a positive Covid test are getting that care because they have Covid and they have other things going on, as well.

The Convener: I will bring you back in for a brief supplementary question, Mr Fraser, but I ask for the answers to be brief, as I really have to move on.

Murdo Fraser: Thank you, convener, and thanks, Professor Leitch, for a very detailed and comprehensive response.

I will make this point briefly. I have been asking these questions for some weeks now and it has been hard to get as clear an explanation as we have just had regarding the numbers. Specifically on the question of the difference in the hospitalisation rates for vaccinated and unvaccinated people, I just ask whether the Scottish Government should be doing more to put out the message to the public. We all want to encourage people to get vaccinated and to get a booster. If the statistics are as clear as Professor Leitch has just stated, it would be really helpful to get that message out so that it is more widely known about among the public.

John Swinney: I agree with that.

Professor Leitch: I agree that that is fair, and I think that Mr Swinney will say the same.

John Swinney: Those messages are communicated by Government. Our clinical advisers have been at the forefront of arguing for the rationale for vaccination and the booster programme, and ministers likewise. At the heart of many of the interventions that we have made—whether on public communication or policy interventions such as vaccine certification—the purpose has been to increase the level of vaccination in the population because it is a compelling protection against the virus. I can assure Mr Fraser that those messages have been and will be communicated by ministers.

Some of the endless speculation about these matters sometimes muddies the waters. It has been crystal clear for a long time now that vaccination is critical as an obstacle to circulation and to protect people against the virus. When we go through all the issues about extra bits of data, it almost leaves the public thinking that there is something that they or the Government are missing about the data, whereas it is actually crystal clear: if you get vaccinated, you have more protection against Covid.

Alex Rowley (Mid Scotland and Fife) (Lab): I re-emphasise the point that Murdo Fraser has made. If we have information demonstrating that people who are vaccinated are much better protected and that the people ending up in hospital are those who are not vaccinated, it is important that we share that.

I want to focus on two areas regarding the latest figures on vaccination. First, our advisers have pointed out to us that there is a tendency for the uptake of the booster to rise with age. However, there seems to be a dip in the number of over-80s who have had the booster. One reason for that might be that many of those people are housebound. What do you think of that? What are you going to do about it?

Likewise, the Scottish Parliament information centre tells us that the uptake of the booster is generally good across the country, but it is poorer in the cities. Glasgow is at 52.6 per cent and Edinburgh is at 59 per cent, whereas the islands are up in the 80s and Fife is in the 70s. There seems to be an issue with take-up. Do you acknowledge that? If so, what are you doing about it?

John Swinney: Obviously, a huge amount of effort is put into securing the take-up of vaccination and boosters. I do not have in front of me the breakdown in the over-70s category—

Alex Rowley: I asked about the over-80s.

John Swinney: In the over-70s group, 95 per cent have had boosters—

Alex Rowley: There is a dip in the over-80s group.

John Swinney: I will look at those figures specifically, but we must have the context that there is a very high level of vaccination among the over-70s. We take a range of steps, such as the prioritisation of care homes for the delivery of the vaccination programme. At the outset, there was a bit of criticism of the Scottish Government that we were not moving as fast as England, but we were doing the painstaking work of making sure that people in our care homes were well vaccinated, and that level has been very high.

Equally, we have to ensure that people who are housebound are vaccinated. I have dealt with a number of cases in my constituency where vaccinations of people who are housebound were undertaken more slowly than people would have liked, but my recent case load indicates that that position is substantially enhanced. I agree with Mr Rowley on the importance of vaccination, but we have to keep a sense of perspective, because we have very high levels of vaccination in those age groups.

Does Niamh O'Connor or Professor Leitch want to add anything to what I have said?

Niamh O'Connor (Scottish Government): I do not want to add anything on vaccinations, but Professor Leitch has requested to speak in the chat box.

Professor Leitch: I will simply give the data, Deputy First Minister. Mr Rowley's premise is correct, and I will give some reasons for that. The vaccination rate for the 70 to 74 age group is 96 per cent; for the 74 to 79 age group, it is 98 per cent; and, for the over-80s, it is 92 per cent. Those numbers are astonishing, when we compare them to the figures across the UK and globally.

The over-80s group is slightly more complex and should not be thought of as one homogeneous group. Again, forgive the shorthand, but quite a lot people in that group are receiving end-of-life care, and we would not vaccinate them. Proportionately, in that group, there are quite a lot of people whom we would not vaccinate for a number of healthcare reasons. However, Mr Rowley is right that, if some people in that group have not been vaccinated because we have not reached them, we should do everything that we can to do so, and I have colleagues all over the country who are working to do precisely that.

My inbox has almost no cases of people who are over 80 and who are waiting to be vaccinated, so I am relatively confident that the health boards have found and boosted all those people. People who live in care homes have been done and most people who receive home visits have been done. If Mr Rowley has individual cases, we are happy to address them. However, do not rely entirely on the percentages, because there is good reason, particularly as people get very old and are near the end of their lives, for them perhaps not to have their booster vaccinations.

Alex Rowley: What about the cities? Nobody has picked up on that. As I said, in Glasgow, 52 per cent of people have had their vaccination, and Edinburgh is a bit higher at around 59 per cent. There seems to be a problem in the cities compared to Fife, which is at more than 70 per cent, and the islands, which are at more than 80 per cent. Is there a problem with people not getting the booster in the cities?

09:30

John Swinney: Obviously, the data will vary from area to area. I am absolutely satisfied that the Government and health boards have put in place adequate opportunities for individuals to secure the booster jag. The level of performance has been very high. We have had surplus capacity, so there has been absolutely no difficulty in getting an appointment for people.

In some circumstances, there will obviously be a time lag. If individuals were slower in coming forward for their first and second doses, they will be delayed in getting their booster dose, because of the time limits that have to be applied. We are not at the end of the booster programme by any stretch of the imagination. It is continuing to vaccinate people on an on-going basis with the appropriate 12-week gap between the second dose and the booster dose. The best way to explain it is that the booster vaccination programme is still a work in progress. I therefore expect those rates of coverage to increase.

We have to continue to intensify the message. One point that concerns me a little is that, if there is a sense that omicron is a less acute variant, that might suggest to people that they do not need to come forward to get their vaccination. However, as Professor Leitch has just explained, there is an absolute necessity for individuals to have the booster vaccination, because it will give them a level of protection that is absolutely critical in dealing with the virus. The Government's messages will therefore remain resolute about the importance of rolling out that booster vaccination programme in all circumstances and all geographies.

Alex Rowley: Given that vaccination rates in the cities are so low, are they giving the Government concern? Are you proposing specific

actions, or are you simply letting the programme run and seeing whether the uptake comes?

John Swinney: We are tackling the issue. We have the capacity available in cities to enable people to be vaccinated. We have headline messaging and marketing, which is encouraging people to undertake the vaccination. Very focused communication has also been issued to individuals who have not had a booster vaccination; we have been communicating with them directly to encourage them to do so.

Given the point that I just made that there may well be time gaps between the moments at which people have been vaccinated, the capacity will be maintained to ensure that opportunities for vaccination are available for individuals. I assure Mr Rowley that the Government intends to maintain the messaging and the communications and approaches to individuals, and that we will maintain capacity to ensure that we can deliver the vaccination programme.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I welcome the panel, and I wish everybody a very happy new year. I hope that everybody had a nice break.

I will go back to Murdo Fraser's and Alex Rowley's point about emphasising the number of people who have not been vaccinated who land in hospital with real illness. We have to continually get that message out. One thing that I am confused about is why there is emphasis on whether people are in hospital because of Covid or with Covid, which I think Jason Leitch touched on. I struggle to see where the differentiation is.

A clinician just gave us some private advice that people, particularly elderly patients, will go in with a condition and discover that they have Covid, and that it is not until she gets to know them better and studies them that she realises that Covid is hampering their recovery. Also, people who are in hospital with Covid still have to go through the process of being isolated and everything else, whether or not it is affecting them. I would like the messaging to get away from whether people are in hospital with or because of Covid, as that muddies the waters. How do we get over that?

John Swinney: I am in a slightly difficult position on that, because I am not the one making the big song and dance about that data. Mr Fraser set out to the committee that he has been demanding that information for a considerable time. The Government has to respond to demands for information and has an obligation to address issues that members of the Parliament raise. Ministers have made it clear that we take the view, which Mr Fairlie expressed, that there is no particular significance in the difference between people being in hospital because of or with Covid.

We have a massive Covid challenge in our healthcare system, and the more that we can do to tackle the prevalence of Covid, the more we will relieve the pressure on that system. The Government's messages have been crystal clear about the dangers of Covid. We have ensured that there is an understanding of the severity of the virus, whether omicron or not, because we cannot have a relaxed attitude prevail that omicron is somehow not a big threat. Omicron is a massive threat to our healthcare system and to public health. We have to get that across to people. That is why the Government has taken strong action to protect the public.

We are not in control of all the questions that we are asked, but we are certainly in control of the key messages about the importance of tackling Covid. Your points about the advice from the clinician are correct, Mr Fairlie. If somebody has an underlying condition and Covid, their ability to deal with the underlying condition will be severely compromised by the presence of Covid. We know that clearly from the clinical advice that we have had.

Jim Fairlie: Will Jason Leitch confirm my latter point?

Professor Leitch: Yes. I will argue against myself slightly, in defence of the data. There are two categories of people who are slightly different from that group but still require infection prevention and control, which will still complicate their recovery.

The first category is extremely straightforward admissions. Let us say that a 24-year-old with no underlying condition breaks their ankle on the ice, comes into hospital and, three days in, tests positive for Covid. That will still affect their recovery—it could severely affect it—and the hospital will still need to behave differently. The second category is people who, unfortunately, get nosocomial spread of Covid. That is, people in hospital or an institution who catch Covid there. That is still possible, although the likelihood is far lower than it has ever been.

If you kind of squint, you could argue that we would want to know about those two groups separately but, in reality, we will still treat them for their disease and their recovery will be complicated because of Covid.

Jim Fairlie: I am conscious that we are out of time. My concern is that the messaging is vital, and I really cannot see why we are worrying about whether people are in hospital because of or with Covid. Given the fact that we have only a 50 per cent uptake of the booster in cities, we need to keep the messaging strong that we have to get the boosters out.

Brian Whittle (South Scotland) (Con): Good morning. I have a couple of questions about data, the first of which is about the collection of data on non-Covid-related issues.

A constituent—a friend of mine, in fact—who, unfortunately, has been diagnosed with stage 3 pancreatic cancer with complications waited six months to get the test. Are we collecting the right data about the stage at which people are being diagnosed with conditions such as cancer, compared with pre-Covid times? Are we collecting data on how many people are being diagnosed with such conditions?

I presume that Professor Leitch would be the best person to answer that question.

John Swinney: I will say a few words before I turn to Professor Leitch.

It is critical that our healthcare system is able to meet the needs of all individuals, regardless of the health condition that they face, recognising the necessity of interventions where they are appropriate. That is one of the reasons why we have to manage and suppress the prevalence of Covid—the more Covid cases there are in our hospitals, the less space there is for other conditions to be addressed. That is the central argument that ministers have set out to the committee, the Parliament and the public on the steps that we have taken to tackle Covid. We have taken appropriate and proportionate action in order to enable our health service to timeously meet the needs of all constituents, such as the person Mr Whittle mentioned, while also dealing with the pressures that come from Covid.

Those are fundamental questions about the capacity of the health service, on which I invite Professor Leitch to give some more detail.

Professor Leitch: I agree whole-heartedly with the Deputy First Minister. Whatever the answer to your question is, the answer to the problem is to reduce Covid infections, which will consequently reduce pressure on hospitals. Bluntly, that will allow us to treat more cancer. Globally, cancer is presenting later—there is no doubt about that—for two principal reasons. One is that people were staying away because they were told to stay away or because they were worried about coming to hospital. That has happened everywhere in the world; Scotland is not immune to that.

The second reason is to do with capacity. Most cancer patients do not have cancer mentioned on their referral letter; most are found because of some other symptom with which they are sent to a hospital and, after a number of visits and tests, they are discovered to have cancer. Some of those people are on waiting lists, whether in Cardiff or in Edinburgh. We have to get to them, and the way to do that is by relieving the pressure on the health service.

Most of the data that I have seen from around the world suggests that late presentation of cancer is becoming more common. I do not know exactly what that looks like in Scotland—we will not know that until we audit it over time—but I would not be remotely surprised if that was the case. The way to fix that is to reduce Covid care and, therefore, increase cancer care.

Brian Whittle: It is totally understandable that we have a capacity issue. There are only so many people who can work in our health service, and Covid has a significant impact on that. My point was about the collection of the data. I point to the potential issues that are coming down the line. I mention that because, in our most recent private session, when we heard from an expert clinician, it was suggested, in relation to our investigation into non-Covid-related conditions, that adequate data is not being collected to make the decisions that need to be made. It is crucial that such data is collected, given the potential future issues that we might face. Who would like to address that?

John Swinney: Mr Whittle raises legitimate points, which come back to points that I made in my previous answer. We must ensure that the needs of the population are met by the national health service. It is the fundamental founding commitment of the NHS that free treatment be provided at the point of need when individuals experience that need. Covid poses a threat to that, because it takes up capacity in our hospitals. More than 1,500 patients are in hospital with Covid. If Covid was not a problem for us, those 1,500 beds could be used for other purposes.

Therefore, the more we can get on top of Covid and reduce the circulation of the virus, the better, because that creates space for patients, such as the people on whose behalf Mr Whittle argues today and, for that matter, has argued consistently for some considerable time.

09:45

The Government has tried to take all the necessary steps to sustain the engagement of critical services for people with conditions that have a life-threatening impact. Along with clinicians and health services, we have worked hard to sustain cancer services. Obviously, for acute presentations of life-threatening conditions, the health service is there to meet people's needs. That is why we look very carefully at the numbers of people who are in ICU with Covid, because we need space in ICU for people who come in because of heart attacks, brain haemorrhages or whatever it happens to be.

Mr Whittle is right to raise those issues, and I assure him and the public that the Government, in its management of Covid, has the patient group that Mr Whittle raises very much in our minds. We want to ensure that their interests are protected.

Brian Whittle: Thank you. I have one final question—I hope that you will forgive me for going here. A lot of data, especially initially, pointed to the fact that the morbidity from Covid came in tandem with high levels of obesity, diabetes and other comorbidity issues, including some of the cancers. That highlights to me that, if we want to treat Covid, we must look at health in a much more holistic way. Does that data not point to the fact that, in the long term, post-Covid, we need to look at our healthcare service in a different and more preventative manner, and do more to tackle the poor health of the nation?

John Swinney: Yes—in whatever circumstance we look at, the Government accepts that argument. We have accepted it for many years and we have taken a number of steps to address it. Some of the available data and detail shows that the challenges that individuals face as a consequence of Covid will be made worse by other weaknesses in their health and fitness.

Mr Whittle makes a strong argument, which the Government accepts, for people to pursue a healthy living approach. Many of our public messages are supportive of such an approach: we encourage people to exercise, look after their health and take preventative action, so that they are in the strongest possible position to withstand the effects of conditions such as Covid or, for that matter, other challenging health conditions that people face in our society. The emphasis on preventative interventions is a core part of the Government's health strategy and will remain so in the future.

John Mason (Glasgow Shettleston) (SNP): A few weeks ago, the number of people in hospital with Covid was under 500; on Tuesday, the number was 1,479 and, yesterday, it was 1,537. Therefore, the numbers are still rising. That is the key figure that I have been watching day by day. When numbers are still rising, is it not too early to relax some of the restrictions, such as those on huge crowds at football and rugby?

John Swinney: It is a very careful judgment that has to be made, and Mr Mason puts a fair and challenging point to me. The situation that we must consider involves a balance of considerations around a number of factors, such as the prevalence of the virus, the presence of hospital cases, the pressures on intensive care and a variety of other social and economic indicators, not least the wider wellbeing of the population, the ability to sustain restrictions and the impact that those might have on the mental and economic wellbeing of individuals.

There is a careful balance to be struck, and I hope that Mr Mason accepts from the explanation that the First Minister gave on Tuesday and that I have given today that, while we are hopeful, the Government continues to take a cautious course in the relaxation of restrictions.

We are taking a phased approach. In the course of the week, I have dealt with a range of broadcast media and handled criticism that the Government did not go further in the relaxation of measures than we did on Tuesday. A number of sectors have strongly expressed those criticisms. In essence, Mr Mason puts to me the counterpoint and asks why we are going as fast as we are going. It is a not unreasonable point.

We judge that enabling some of the larger events—such as those in outdoor football stadiums, where vaccination certification and lateral flow device testing are required among at least 50 per cent of the crowd—to take their course is a reasonable first step in the relaxation of restrictions while we consider whether, with the benefit of another week of data, we can see a wider improvement in the situation that allows us to relax measures further. I acknowledge that it is a careful balance, and it is one with which the Government wrestles with a great deal of consideration.

John Mason: I take the point about balance. I suspect that you will give me a similar answer to my next question, which is about self-isolation. We were at 10 days for the self-isolation period and we are now at seven. I think that the United States is at five. How are we getting the balance? What is the thinking about exactly how long the self-isolation period should be?

John Swinney: Again, it is the balance question. In a moment, I will invite Professor Leitch to give some detail on the clinical justification for the change, because we need to hear that. Ministers have heard it and come to conclusions about it.

There is an important perspective that has to be borne in mind. It goes back to many of the questions that we have wrestled with as ministers and shared with the committee on a number of occasions about the four harms framework. Multiple harms are created as a consequence of Covid. Loss of economic wellbeing is one of them. Loss of social interaction is another. Ministers have to be conscious of those factors when we take decisions on matters such as self-isolation.

We have been criticised for taking too long to relax the self-isolation rules, but we took an appropriate amount of time to make the judgments within the context of the arrangements for, and the

policy approach that we have taken to, managing the pandemic. That will be an important point in relation to the judgments that we will have to apply in the future.

I invite Professor Leitch to add some remarks on the clinical explanation for the relaxation of the self-isolation requirements.

Professor Leitch: It is a balance, Mr Mason. We went from 14 days to 10, if you remember, as we learned more about the virus and the risks that it poses in our position. That refers not only to the state of the pandemic—the number of cases that we have—but the science that is available.

We would not have gone from 10 days to seven without testing, for example. The UK Health Security Agency, who are the real boffins and do the risk adjustment for us, said that 10 days with no testing is about the same risk as seven days with two tests. It was a relatively straightforward piece of clinical advice to give to politicians to say that—this is not exact, of course, because there are confidence intervals in the statistics—roughly speaking, a self-isolation period of 10 days with no tests is about the same risk as one of seven days with two tests.

France and the US have gone to five days, with testing, so we need to know what the percentage risk would be of releasing infective cases on day 5. What the US and France have done has been a little bit misunderstood. They are doing five days of isolation, with release on day 6, which is only one day less than us, so the headline is not quite right. In France or America, somebody would test and get released on day 6; we test now and release on day 7 if both tests are negative.

We do not yet know what the percentage risk would be. That clearly changes depending on whether you have 15,000 cases or 150 cases in your community. If you have 150 cases in your community, you can take more risk because you are less likely to meet positive cases. If you have 15,000 cases, your risk is higher. It is not only a matter of the percentage risk that you would be taking by release; it is also about the number of people in your community who are positive.

We will take the UKHSA advice, as will the other three countries in the UK, adapt it for the state of our pandemic and give appropriate advice. My instinct is that we have only just moved from 10 days to seven, so we need to let that work through in the real world. The theory is one thing. People doing lateral flow tests in houses with kids and pets running around their legs does not really work in the same way that it works in the laboratory. Therefore, we need to see what happens with moving from 10 days to seven before we give advice about moving from seven to, in effect, six.

John Mason: We heard a lot about vaccination passports, especially in September, when there was a lot of discussion about them, but we have not heard so much about them recently. Is it right that, in the next few weeks, we might make greater use of them? If a vaccination passport is required—I say “vaccination passport”, although I realise that the correct term is “vaccination certificate”—would a negative test also be accepted?

John Swinney: The Cabinet will consider the steps that we will take on any future expansion of the vaccination certification scheme. That scheme works well. I fail to understand what the fuss is about. I think that it is a completely reasonable request for us to make. The arrangements are in place, and it functions well.

As I indicated in my response to oral questions in Parliament yesterday, in a system that involves more than 10 million individual vaccinations, there are bound to be teething issues on certain vaccination certificates. I have made it clear that ministers will help to resolve any issues. Indeed, I got an email last night from a gentleman who is not a constituent of mine who was looking for my help to solve a vaccination certification issue. That is under way. We will resolve such minor issues when they arise, but the vaccination certification scheme works perfectly well.

In our discussions on Tuesday, the Cabinet will consider any future expansion. We have put in place steps that enable negative lateral flow device tests to be an alternative to vaccination certification. That would remain an option for us to use in any future expansion and the Government will, of course, consider that.

The Convener: That concludes our consideration of that item and our time together this morning. I thank the Deputy First Minister and his supporting officials for attending.

The committee’s next meeting will be on 20 January, when we will again take evidence from the Deputy First Minister and Cabinet Secretary for Covid Recovery.

That concludes the public part of our meeting. I move the meeting into private.

09:58

Meeting continued in private until 10:16.

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