OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 20 January 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 20 January 2022

CONTENTS

COVID-19 RECOVERY COMMITTEE

2nd 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:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Professor Jason Leitch (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 20 January 2022

[The Convener opened the meeting at 10:30]

Ministerial Statement, Coronavirus Acts Report and Subordinate Legislation

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/475)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 13) Regulations 2021 (SSI 2021/478)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 6) Regulations 2021 (SSI 2021/496)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 7) Regulations 2021 (SSI 2021/497)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 8) Regulations 2021 (SSI 2021/498)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment Regulations 2022 (SSI 2022/2)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment Regulations 2022 (SSI 2022/6)

The Convener (Siobhian Brown): Good morning, and welcome to the second meeting in 2022 of the Covid-19 Recovery Committee. We have received apologies from Alex Rowley MSP and are joined by Jackie Baillie MSP, who is attending as a committee substitute. Ms Baillie, I welcome you to the meeting and invite you to declare any relevant interests.

Jackie Baillie (Dumbarton) (Lab): Thank you. I have no relevant interests to declare.

The Convener: Thank you.

Brian Whittle is running slightly late, so he will be joining us later.

This morning, we will take evidence from the Scottish Government on the latest ministerial statement on Covid-19, subordinate legislation, and other matters that are noted on the agenda. I welcome 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 Elizabeth Blair, Covid co-ordination directorate. Thank you for your attendance. Deputy First Minister, would you like to make any remarks before we move on to questions?

The Deputy First Minister and Cabinet Secretary for Covid Recovery (John Swinney): Thank you, convener. I am grateful to the committee for the opportunity to discuss a number of matters, including the updates to the Parliament on Covid-19. I will make a brief opening statement.

As the First Minister set out on Tuesday, although omicron continues to cause high levels of cases and we must maintain proportionate protective measures, the data that we are seeing gives us confidence that we have turned the corner on the omicron wave. Although the number of cases remains high, we continue to see a reduction in cases across most age groups. Admissions to hospital of people with Covid, albeit still too high, are now falling.

The success of our vaccination programme, the willingness of the public to adapt its behaviour, and the temporary protective measures that were introduced in December have all helped to limit the impact of the omicron wave. That is positive news but, given how infectious omicron is and the impact that it is having on our society, we must remain careful and cautious as we continue to lift additional protective measures in a phased approach.

The First Minister confirmed that, from Monday 24 January, the remaining statutory measures that were introduced in response to omicron will be lifted. Those include the requirement for table service in certain hospitality settings and the closure of night clubs. Non-professional indoor contact sports can also resume from Monday.

Although it remains sensible to stay cautious in our social interactions and to prioritise whom we meet, the First Minister also confirmed that the guidance asking people to limit indoor gatherings to three households will be lifted. Our advice remains to take a lateral flow test, and to report the result, whenever meeting others. Reporting test results, including those that are negative, will ensure that we are able to make better assessments of the trends in infection.

The Covid vaccination certification scheme will remain in place for events and venues that were previously covered by it, and we are asking event

organisers to check the certification status of more people who are attending events. This week, the Cabinet agreed not to extend the certification scheme, given the improving situation. For the time being, baseline measures, such as wearing face coverings in indoor places and working from home, when that is possible, will remain in place. The requirement for businesses, service providers and places of worship to take reasonable measures to minimise the spread of Covid on their premises will be retained, at this stage, to help keep Covid contained as the current wave recedes.

Our vaccination programme continues, and I encourage anyone who has not yet had their first, second or booster dose to do so as soon as possible. Getting fully vaccinated is the most important thing that we can do just now to protect ourselves and each other.

The First Minister said on Tuesday that we are entering a calmer phase of the epidemic. That will allow us to consider the adaptations that we might need to make to build our resilience and to manage the virus less restrictively as we move into an endemic phase in the future. We have not yet reached the endemic phase and must remain cautious, given the uncertainties that lie ahead.

I am happy to answer questions from the committee.

The Convener: Thank you. We are short of time, so I ask for concise questions and answers.

Thankfully, the omicron wave is decreasing, although we are cautiously aware that there could be new variants in future. How is the integrity of surveillance for new variants being maintained, given that polymerase chain reaction tests will not now always be required for people who have had a positive lateral flow test?

John Swinney: Professor Leitch can provide some of the epidemiological information. A huge amount of surveillance data is still available to Government. Substantial numbers of PCR tests are still being undertaken, there are wider studies, and scientific information is exchanged across a number of jurisdictions, all of which enables us to create a commanding picture of the available information. The detection of the omicron variant was made far more practical by the correlation with the S-gene dropout element of the assessment.

There will be a range of scientific interventions that we can make to ensure that that situation continues. Professor Leitch can provide more data.

Professor Jason Leitch (Scottish Government): It is a global problem and not one that Scotland can solve alone. We discovered omicron because a large outbreak in a region of South Africa looked different from other outbreaks and seemed to be transmitting very quickly. That then moved to Hong Kong, where genetic sequencing found a variant that looked more transmissible. Genetic sequencing back in South Africa confirmed that pattern and the World Health Organization announced that to the world.

The discovery of new variants is not a Scottish problem, but a WHO problem. The WHO has a surveillance problem and has solutions around the world. South Africa has some of the best genetic sequencing in the world, as does Scotland, and we will continue doing that on behalf of the world. The first challenge is to find a new variant. The second challenge is to monitor the variant, once we know that it exists. We managed to do that with S-gene target failure and we would do that again.

We still have quite a lot of PCR tests. We have PCR tests for every hospital case and every symptomatic case that turns up, and we have them from the Office for National Statistics survey. We still have quite a lot of PCR testing that can then go for genetic sequencing. I am very comfortable that we can still sequence enough tests to find out what is happening.

There are thousands of variants. The virus changes every day. What matters is whether a variant causes a new challenge, which might be its rate of transmission or the instance of serious disease. That requires real-time data, such as monitoring numbers of cases or of hospitalisations. That might happen in Scotland. Proportionately, or by good luck, it is more likely to happen in another country. It could be here, but it is more likely to be somewhere else. We must work globally, not just in Scotland. I am comfortable with our own surveillance system, but the proviso is that we need the whole world to be able to do that.

The Convener: With the omicron variant, people are being encouraged just to do a lateral flow test rather than a PCR one and to self-isolate for the required amount of time. Then they try to get a self-isolation support grant from their local authority. This week, I have heard from constituents who have been told that they are not eligible because they need a negative PCR test and a lateral flow test is not enough. For people who test positive and need to get a grant, there is a gap between lateral flow tests and PCRs. How can we tie that up?

John Swinney: There should not be an issue there. Individuals who are required to self-isolate, which is the case if someone tests positive with a lateral flow device test, should be eligible for a self-isolation support grant. If there is an issue with that, I will look into it carefully with local authorities to ensure that people who require such support

are able to obtain it, given the requirement for them to self-isolate due to the arrangements that we now have in place.

The Convener: That is very helpful—thank you. We will move on to the next question.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, cabinet secretary and colleagues. I have two questions and, given that we are short of time, I will ask them both together.

Cabinet secretary, you said a moment ago that the Scottish Government's view is that Covid has not yet reached endemic status in the Scottish population. Do you have any modelling or projections as to when that will happen?

My second question is on the impact of omicron. As you have said, there has been a very high number of cases, but the number of hospitalisations is now tailing off. If we cast our minds back to where we were in December, the committee was being advised that omicron could result in thousands of additional deaths. Fortunately, the impact has been nothing like that. Given that there are likely to be more variants of Covid, is there a risk that, if that happens, the public will say that experts and advisors have been crying wolf over the impact of omicron and will therefore be resistant to measures being taken to safeguard the population? The experience of omicron has been nothing like as serious as was originally forecast.

John Swinney: In a moment, I will ask Professor Leitch to deal with the question of epidemic and endemic, because judgment with a clear scientific basis has to be applied to that, and it is appropriate that he provides the committee with that advice.

On the second question, there is one point of detail in Mr Fraser's analysis on which I part company with him. From my recollection, I do not think that the projection or suggestion was made that omicron would lead to a significantly greater number of deaths. The fear of omicron was that a huge volume of cases would give rise to a large volume of hospitalisation, which would place a burden on the national health service. In the emerging evidence from South Africa, it appeared that omicron, although generally a milder version than delta, would still give rise to a sizable number of cases in the population that would result in hospitalisation.

I would contend that the combination of the measures that the Government put in place, the response of members of the public and the change in behaviours that took place in the run-up to Christmas enabled us to flatten the omicron curve. The number of cases was of a magnitude that would have led to much more acute measures being taken with previous variants; it was much higher than the number that resulted in the lockdown of 4 January 2021, for example. In the position that materialised, the combination of the vaccination strategy, the measures and restrictions that were put in place by the Government and the change in public behaviour and participation enabled us to flatten the worst effects.

However—we must be really careful about this point—we still have huge demands on the NHS as a consequence of omicron. We have more than 1,500 patients in hospital with Covid just now. That is a very high number, which is putting acute pressure on the national health service.

10:45

Professor Leitch: I will respond briefly to question 2, and then I will answer the question on endemic status.

When omicron first emerged, we simply did not know whether the rumours—let us call them that—of slightly milder disease were true. Nobody knew. However, we knew pretty quickly that booster doses of vaccines were crucial, and we were able to vaccinate, at one point, faster than any other country in the world.

The omicron wave has not been as damaging as we thought that it might be, because of the combination of protections, human behaviour and vaccination, with the contribution from the virus that, in the end, it is milder than the delta version. Unpicking how much of that has been down to the virus and how much has been down to vaccination will take months, but the combination of all those things is why we have not seen omicron reach the absolute worst that we thought that it might. That is a credit to the national health service vaccination teams and to the public, who reduced their contacts appropriately, partly because we told them to and partly voluntarily.

The term "endemic" is a little misunderstood. The disease that everybody suggests is endemic is flu. Endemicity is about predictability. An endemic disease is defined as one that is in an area of the world and which is relatively predictable, so we know when it is coming and what it is going to do. Endemicity says nothing about severity. Malaria is an endemic disease and kills 600,000 people a year, not here, but among the billions of people who catch it in sub-Saharan Africa and south-east Asia. Endemicity is not about ease or making it better—it is about predictability.

For now, Covid is unpredictable. We do not know when the next wave is coming or whether it will be better or worse than the previous waves. The WHO will decide when the disease becomes endemic. Just now, the WHO says that it is a

pandemic, and the definition of that is that every single person on earth is at risk from it.

The WHO will decide when it is more predictable, which I hope will happen in 2022, although nobody knows whether it will. How Scotland and other countries choose to deal with the next year of the pandemic is the core of Murdo Fraser's question. What do we do, and how should we react, as the disease moves into another year of being a pandemic?

That is the question that the committee has been asking, and to which the Government has tried to respond, throughout the whole period. I am not sure that it is about having an intellectual conversation on pandemic versus endemic; it is about how we manage a pandemic. As we have discussed, that has global implications around genetic sequencing, and for our strategic framework, which we are refreshing—the Government will announce the results of that in the next few weeks.

Jackie Baillie: Good morning. You will be aware that the Scottish Government stopped fertility treatment for those women who were not fully vaccinated on the day before Christmas eve, with no notice being given. I understand that, on 7 January, the Scottish Government then extended the suspension to include treatment in the private sector.

As I am sure you can imagine, the women who were preparing for treatment in early January were distraught, to be frank, and they went through considerable emotional turmoil. In some cases, women were vaccinated but, because they had caught Covid, they could not get their booster in time and their treatment was cancelled, too. There was a real feeling that the lack of an individual approach, with the blanket ban, was not fair on many of the women who were involved.

Other women have since been in touch because they are genuinely confused. The advice from health professionals at the very start of the Covid pandemic was that pregnant women and those who were expecting to be pregnant within the next three months should not be vaccinated. You and I both know that that advice has since changed, but it strikes me that there is genuine confusion.

I have three questions. First, can you get clinicians to explain to those women who are undergoing fertility treatment how the guidance has changed, and to reassure them? Currently, there is confusion. Secondly, as cases are starting to decline, when will the service be resumed, and will it be conditional? Thirdly, will women who have been caught up in and affected by this issue get an extra cycle of in vitro fertilisation to make up for what has been lost?

John Swinney: I recognise the significance and sensitivity of the points that Jackie Baillie is raising with me. I will draw on input from Professor Leitch in addition to what I say, but first I will try to provide some reassurance.

The advice that emerged from clinicians—I stress that it was clinical advice that led to the decision to pause fertility treatment—was based on what was overwhelming evidence that indicated that the necessity for vaccination was critical in those circumstances. That was certainly my reading of it. I do not have all the details in front of me, but research was undertaken on the proportion of pregnant women who were admitted to critical care as a consequence of Covid. From my recollection, well over 90 per cent of those cases were women who were unvaccinated. The clinical evidence was overwhelming in that respect, which led to the pause. I quite recognise the distress and upset that that would have caused to the individuals who were affected.

There should be good explanation of the rationale. I have looked at the material and I have seen very clear and well-expressed clinical opinion and evidence on the subject. That should be shared with individuals in all circumstances.

The second question that Jackie Baillie asked was on the resumption of fertility treatment. That will happen as soon as the vaccination programme has delivered the degree of protection that we consider necessary in the context of the omicron wave.

I will seek clarification from Jason Leitch but, on the last question, I think that the Government has made it clear that there will be no disadvantage to any women who were going through fertility treatment. They will not in any way lose out on the opportunity to pursue that fertility treatment because of the pause in arrangements that has been put in place. I would be grateful for Professor Leitch's input on that question.

Professor Leitch: The third question is the easiest. There will be no disadvantage to couples whose IVF treatment has had to be paused. There will be an extension of the time and, if necessary, an extension of the cycle, depending on where they were in the cycle when the clinically based decision was made.

It was awkward timing, of course. The timing of clinical decisions is often awkward, because clinical decisions do not know the calendar. It was completely risk based. The decision was about the safety of women and babies, and it was not made lightly. It was a very hard decision because of the nature of the disease and, in particular, what it does to high-risk individuals—who, I am afraid, include pregnant women, whether or not they have had IVF.

People in those individual cases should be having conversations with their care teams in fertility units around the country, whether those are public or private. I have been having some of that conversation at a national level, in both the media and stakeholder groups, but I cannot have individual conversations with each couple and doing so would be inappropriate. Those individual conversations should be taking place with case leaders, who certainly have the information, because the advice came from many of those clinicians.

Ms Baillie's second question, which was about when we will restart treatment, is the hardest. It is not about case rates; it is about the risk of Covid if you are pregnant. That risk will remain whatever the case rate is. The way to restart is to get vaccinated. We know that vaccinated pregnant women are much safer than unvaccinated pregnant women.

You made a point about the advice on vaccination at the very beginning of the pandemic. That advice lasted literally a few weeks. It was all about the fact that we had not vaccinated pregnant women so the research could not be done. We could not say what people should do if they were pregnant because we had not vaccinated pregnant women in the research trials. While we did the rest of the research on pregnant women and kidney transplant patients, it was a precautionary measure to tell pregnant women not to have their vaccines at that point. However, as soon as the trials with pregnant women were done and it was proved to be safe, we told pregnant women to get their vaccines.

I understand why that might be confusing to some people, but pregnant women have now been vaccinated safely in their hundreds of thousands around the world, and that is what we have been doing in Scotland for a long time. The way to restart IVF is to get vaccinated.

The Convener: We move on to questions from John Mason. If we have enough time at the end, I will come back to members for supplementary questions.

John Mason (Glasgow Shettleston) (SNP): In yesterday's *Herald* newspaper, there was a column by Stuart Patrick, who is the chief executive of Glasgow Chamber of Commerce. He argues that this is the time to move within the four harms framework, give less priority to direct health harm and give more priority to other health, social and economic impacts. Obviously, he is particularly interested in the economic side. How does the cabinet secretary respond to that?

John Swinney: The four harms framework to which Mr Mason refers, which we put in place in the summer of 2020, has been an essential guide in ministers' decision making. It has enabled there to be a transparent and open conversation with the public and a range of interested parties about the nature of the decisions that have had to be considered.

In March and April 2020, direct Covid health harms were exclusively determining the decision making, because we were in such an acute moment of crisis. From the summer of 2020 onwards, we have sought to strike a balance across the four harms. That is reflected in the strategic purpose of the Government's agenda, which is to try to manage the Covid pandemic in a way that enables people to appreciate and enjoy as many aspects of normal life as possible, and it remains the rational and considered approach that the Government should take.

If we disregarded direct health harm, the health service would be overwhelmed before we knew it. That would have been the case in December with omicron. If the Government had ignored the direct health harm, the health service would have been overwhelmed—there is no doubt about that in my mind—and the degree of direct health suffering would have been much greater for members of the public. Not many people in society would think that that was a rational approach for the Government to have taken.

The strategy that we have adopted has been to take difficult but evidenced and considered decisions on the balance of the four harms in order to protect public health while enabling people to appreciate and enjoy as much of normal life as we could hope to achieve in the context of a global pandemic.

John Mason: There was some coverage in the media yesterday about compulsory vaccinations. Specifically, it was about an offshore company—I think that it was CNR International—that is insisting that all its employees be vaccinated before they go offshore. What is the Government's current thinking on that? You have no control over what an oil company might do, but are you relaxed about organisations insisting on vaccination? I do not think that the NHS in Scotland has been doing that up to now.

11:00

John Swinney: The Government's position is that we will not mandate people to have a vaccination. It is a voluntary programme. An individual organisation is free to take such an approach, but I would counsel that it needs to engage constructively with its employees on such questions, because the issues around approaches of that type will undoubtedly have an effect on who would be eligible and available for employment in

such a context. It is up to individual employers to undertake those discussions.

John Mason: I have a final factual question. There has been talk about charging for LFTs. What is the cost of an LFT?

John Swinney: The last cost that I saw was something of the order of £3 per test, but I stand to be corrected by one of my officials.

Professor Leitch: That is also my understanding. I think that the cabinet secretary saw the same briefing that I saw. The cost was about £3 per test. That is a calculation from many hundreds of millions of tests divided by the total cost, so I am not sure that it is entirely accurate, but it is about £3 a go.

Brian Whittle (South Scotland) (Con): A report that I was looking at on the incidence of lung cancer over the piece says that half of lung cancer diagnoses are being made at stage 4 and that, during Covid, there has been a 25 per cent reduction in diagnosis and a 25 per cent reduction in treatment. The report also says that a lung cancer screening programme should be required, specifically for over-50s and smokers. I understand that you and the Government have to balance the decisions that you have to make, but where are we with gathering those statistics, considering them and making decisions on that basis?

John Swinney: I contend that the relevant data is clearly available because Mr Whittle has just recounted it to me. The collection of such data enables us to see comparative levels of referrals for individual cancer treatments and a variety of other treatments, the number of cases that have been handled and the period and time at which they have materialised.

A sustained effort has been put in to maintain cancer services throughout the challenges of the pandemic. When other services were paused, cancer services were maintained. However, I have to acknowledge that individuals will have been more reluctant to come forward for wider health treatment during the pandemic, and the evidence and data reinforce that point. It is important to reiterate the necessity for individuals to come forward for treatment of this type. When people have concerns about their health, the national health service is open and available to deliver treatment to them. It is important that, at all stages, individuals hear the message that the health service does all that it can to deliver.

Obviously, the capacity of the health service to deliver in that respect depends on the degree to which we can suppress the effects of Covid on it. The omicron wave has essentially reinvigorated the number of patients who are in hospital with Covid. If we look back to just before omicron, we were down to about 900 patients being in hospital with Covid—I think that the number was actually lower than that—but we now have in excess of 1,500. Suppressing Covid enables the health service to devote more resources to addressing the type of condition that Mr Whittle fairly puts to me as being important to members of the public.

Brian Whittle: I understand that the Government has to balance a lot of different factors. However, we know from the numbers that people who are in hospital with Covid or who tragically lose their lives to Covid predominantly have other issues as well as Covid, which Covid exacerbates. Because this is the COVID-19 Recovery Committee, I am trying to look ahead. It is really important that we do not lose sight of the fact that those who are in hospital with Covid usually also have some other issue.

It might seem a moot point, but health boards have, for example, and understandably, missed their smoking cessation targets because of Covid. How do we balance that and pull that back together? It is almost a chicken-and-egg situation. If we could reduce—[*Inaudible*.]—causing significant health impacts by treating other issues, perhaps we could reduce the impact of Covid. How does the Government balance those issues when it makes decisions?

John Swinney: Essentially, that is reconciled through the four harms framework that I discussed in my answers to John Mason. I will remind the committee of the details of that. The Government has assessed the relationship between health harm directly from Covid, non-Covid health harm and economic and social harms. Although Mr Whittle is correct to say that some people who have lost their lives to Covid will have had other conditions, other people have lost their lives directly because of Covid.

The Government has been trying to enable people to experience as much of normal life as we can hope for while we wrestle with a global pandemic. That has a bearing on the extent and nature of the health treatments that are available and that can be delivered.

All the preventative health interventions that the Government supports—such as the smoking cessation programme that Mr Whittle mentioned—need to be part and parcel of what we put forward to members of the public as vital elements of the health protection that individuals ought to pursue in order to lead a healthy life. That should be sustained during Covid, and any treatment as a consequence of that needs to be sustained in that context as well.

Although it is important that we focus on additional health harms that are different from those that are caused by Covid, the hard reality is

that it is inevitable that the capacity of the national health service to address those issues will be greatly enhanced if we ensure that there is less impact on the health service as a consequence of Covid.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I have two questions. One is very narrow, which I will probably direct—[*Inaudible.*].

Deputy First Minister, there are lots of reports in this morning's newspapers that the Scottish Government is coming under pressure because of the English Government's removal of the requirement to wear face masks in schools. I find it frustrating that, because England has done that, Scotland seems to be asking to follow. What is the Scottish Government's position on face masks in schools?

In the interests of time, I will also ask my second question, which is about medical exemptions. I understand that there are four categories of medical exemption. In the case of someone who has an underlying health risk, would anxiety about their underlying health be considered part of an exemption right for them not to be vaccinated? I am not advocating that such a person not get the vaccine; I am simply putting a specific constituent question.

John Swinney: On Mr Fairlie's first question, the Scottish Government's position on the wearing of face coverings—whether in crowded public places, on public transport or in schools—has not changed in the light of yesterday's announcements by the Prime Minister. There is absolutely no change in the Scottish Government's position, of which Parliament was advised on Tuesday. If there was to be any change in that position, Parliament would be advised. As things stand just now, the Scottish Government is crystal clear that the requirement to wear face coverings in public spaces, on public transport and in secondary schools remains absolute.

I am struck by yesterday's comments by the chair of the British Medical Association council, Dr Chaand Nagpaul, who said:

"It is vital that the Government"—

the UK Government—

"acts according to the data and takes a measured approach. Removing effective infection control measures like mask wearing on public transport and indoor crowded spaces will inevitably increase transmission and place the public at greater risk, especially for those who are vulnerable."

Those are very significant words of warning, which are taken seriously by the Scottish Government.

I invite Professor Leitch to address Mr Fairlie's second question, which was about clinical advice.

Professor Leitch: We have enormous sympathy for those who are anxious about vaccination itself and for those who are anxious about their underlying condition, which makes them anxious about vaccination, but neither is an appropriate exemption from being clinically vaccinated. That is why we have systems in place to help with that. The first thing that I suggest those individuals do is speak to their care team, if they have such a thing. If they have a disease that requires them to have a regular clinical team, they should speak to that team, and then they should speak to a vaccinator.

We have tiered levels of vaccinators. The first vaccinator you meet may well not be able to answer every question you have, but in every clinic we have team leaders, and we have trained individuals who can talk you through the process. Nobody will force you to be vaccinated, and nobody will inject you without your consent, but the best place to have those conversations is within your clinical team or in the vaccination centre.

The Convener: We have a little bit of time on our hands, so I will bring back Murdo Fraser, who has a constituency question.

Murdo Fraser: Yes, I have a question that has come to me from a constituent; Jason Leitch might be best placed to respond to it. The situation is that the constituent was double vaccinated, and he then caught Covid. He has not yet had a booster. Under the vaccination certification scheme, he requires to get a booster. The point that he is making is that, having now had Covid, he would have natural immunity. Is it necessary for him to get a booster? What is the science behind that requirement?

I do not know whether Jason Leitch can help with that point.

Professor Leitch: Yes, I can. It is necessary for him to get his booster as soon as he possibly can. We have discussed the nature of immunity before in the committee: it is not a light switch; it is a dimmer switch. Natural immunity and vaccine immunity do slightly different things at slightly different times. It is a case of the more, the better, so he should absolutely get his booster as fast as he can.

We leave a gap, principally to allow people to recover from symptoms, so that they feel well enough to have the vaccine, and also to separate side effects of the vaccine, if there are any—that is rare and unusual—from those of the disease. The advice to the individual in question is that they should absolutely get the booster as soon as they can, and that it will do them good, not harm.

Murdo Fraser: That is very helpful—thank you.

The Convener: That concludes our consideration of that agenda item. I thank the Deputy First Minister and his officials for their evidence.

We now move on to the second agenda item, which is consideration of the motions on the made affirmative instruments that we considered during the previous agenda item. Deputy First Minister, would you like to make any further remarks on the SSIs that are listed under agenda item 2 before we consider the motions?

John Swinney: In the interests of time, I will not put any further points on the record.

11:15

The Convener: Are members content for the motions to be moved en bloc?

Murdo Fraser: I am sorry to pre-empt you, convener. I am content for the motions to be moved en bloc, but I want to make a point on SSI 2021/475. We have been advised that the Delegated Powers and Law Reform Committee considered that instrument on 11 January and disagreed to it on the grounds that the committee was dissatisfied with the use of the made affirmative procedure.

I think that we should simply note that. As it happens, the measures in the instrument are, of course, now historical and, on the basis of the announcements that were made earlier this week, will be removed next week. Therefore, I do not think that there is any point in us voting against the relevant motion, but we should note the concerns of the Delegated Powers and Law Reform Committee.

The Convener: We will note those concerns. Members agree to the motions being moved en bloc.

Motions moved,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 5) Regulations 2021 (SSI 2021/475) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No. 13) Regulations 2021 (SSI 2021/478) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 6) Regulations 2021 (SSI 2021/496) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 7) Regulations 2021 (SSI 2021/497) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 8) Regulations 2021 (SSI 2021/498) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment Regulations 2022 (SSI 2022/2) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment Regulations 2022 (SSI 2022/6) be approved.—[*John Swinney*]

The Convener: I note that no member wishes to speak on the motions.

The question is that motions S6M-02594, S6M-02602, S6M-02698, S6M-02699, S6M-02760, S6M-02733 and S6M-02799 be agreed to. Are we agreed? If any member disagrees, please put an N in the chat.

Nothing has been put in the chat, so the motions are agreed to.

Motions agreed to.

The Convener: The committee will publish a report to the Parliament setting out its decision on the statutory instruments in due course.

That concludes our consideration of that agenda item and our time with the Deputy First Minister. I thank him and his supporting officials for attending. The committee's next meeting will be on 27 January, when we will consider the Coronavirus (Discretionary Compensation for Self-isolation) (Scotland) Bill at stage 2.

That concludes the public part of the meeting. I suspend the meeting to allow the witnesses to leave.

11:17

Meeting continued in private until 11:26.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba