OFFICIAL REPORT
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COVID-19 Recovery Committee

Thursday 17 March 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 17 March 2022

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COVID-19 RECOVERY COMMITTEE

9th 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)
John Swinney (Deputy First Minister and Cabinet Secretary for Covid Recovery)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 17 March 2022

[The Convener opened the meeting at 09:05]

Excess Deaths Inquiry

The Convener (Siobhian Brown): Good morning, and welcome to the ninth meeting in 2022 of the COVID-19 Recovery Committee.

This morning, we will conclude our evidence taking on the inquiry into excess deaths in Scotland since the start of the pandemic. I welcome to the meeting Humza Yousaf, Cabinet Secretary for Health and Social Care, and Professor Jason Leitch, national clinical director for the Scottish Government.

Cabinet secretary, would you like to make some short opening remarks before we move to questions?

The Cabinet Secretary for Health and Social Care (Humza Yousaf): First of all, convener, I apologise for being slightly late. In view of the fact that I am slightly late, I am more than happy to pass back to you and go straight to questions and answers so that we have as much time as possible for that.

The Convener: Thank you very much. What is your interpretation of the data on excess deaths during the pandemic? In particular, what is your view on Public Health Scotland's submission, which says that

"from July 2021 onwards the pattern changed, with almost all causes of death being in excess"?

Humza Yousaf: I will say a few things about that. First and foremost, I welcome the committee's inquiry into the matter and its detailed analysis. I have had time to read over and, when I have been able, listen to the evidence that you have taken. It has been a reminder for every person around the table of how sobering the data is and how every person in Scotland has been touched in some way by tragedy involving Covid. That could be anything from an individual in a family who has suffered from long Covid right through to people who have been bereaved by Covid. People talk a lot about statistics and numbers in the committee, and with good cause, but I remind everyone that, behind each of those statistics, there is a human tragedy.

We know that, since the start of the pandemic, there have been 12,140 excess deaths from all causes. That figure is 11 per cent higher than the five-year average, which demonstrates Covid-19's impact. Over the same period, there were 13,429 deaths involving Covid, and Covid was the underlying cause of 11,443 of them—85 per cent of all the deaths involving Covid. Therefore, the excess death measure during the pandemic clearly demonstrates Covid's impact.

On how the pattern changed in the latter half of 2021, I strongly associate myself with remarks that you heard in previous evidence sessions such as those by Dr Lynda Fenton, who is a public health medicine consultant at Public Health Scotland. She recognised that, in view of the breadth of the situation, it is likely that there will have been health service factors—I am certain that we will get into that in the committee discussion—as well as factors that are related to the determinants of health. Peter Hastie from Macmillan Cancer Support—I have a lot of time for him as an individual and for Macmillan Cancer Support—made the undebatable point that people with cancer are being diagnosed later than they were before the pandemic. That is also a factor in the figures.

In the latter half of 2021, the vaccination programme was well into its stride, and there is no doubt that vaccines have played an important role against the severest impacts of Covid and, of course, Covid mortality. That might be demonstrated in the figures, too.

Professor Leitch might want to add something to that, given his clinical expertise in the area.

Professor Jason Leitch (Scottish Government): I will go back a step, because we have had a two-week break since we last spoke, which is unlike us. Last week, a very important paper on excess mortality was published in *The Lancet,* which looked at the whole world for the first time. We always knew that such work would take time, and we all knew that the chat about the United Kingdom having the worst mortality in the world would not be true in the longer term—and sure enough, it is not.

The authors of that paper on excess mortality looked at data from pretty much every country that they could get their hands on, which was about half the world. Death certification in the UK and in most of western Europe is exemplary, but in much of the world it is not. On excess mortality, the global average in the first two years of this horrible infectious disease is about 100 deaths per 100,000 of the population. Twenty-one countries have more than 300 deaths per 100,000. India has among the highest rates, and Russia and the United States have 300 deaths per 100,000. The raw numbers are eye watering. Four million people in India have died of this disease, which is remarkable; almost the population of Scotland has

died of Covid and Covid-related disease in one country.

The UK's numbers—126 deaths per 100,000—are around the global average, but there are confidence intervals, of course, because of the nature of the statistics. All four countries of the UK are—forgive the shorthand when we are talking about death—in the middle of the pack, which is roughly where we all thought we would be. We have been trying to get there through vaccination, lockdowns early on and the provision of safety measures since.

It is important to put excess deaths in context, because we now have Covid but have no flu, and we have Covid but have the economy open and so on. The number of excess deaths in a week is irrelevant, but the number over a period such as a global pandemic is crucial. That is how we will judge the public health measures of the world over the long term. I was shocked and once again miserable when I read the toll that this disease has taken, but the UK has behaved and performed relatively well from a public health perspective, if we look at the whole thing.

I will give some final headline numbers. The number of Covid deaths that have been announced by every country in the world is about 5 million. The actual number of Covid deaths is 18 million. That gives you the difference. Our numbers—the UK and Scottish numbers—relate almost exactly to the numbers that we have announced. Our excess mortality number is pretty much the same as the number that we announced for deaths from Covid. There are massive differences in those numbers in other countries because they do not have a mature death certificate system and so on.

The Convener: It is important that we consider Scotland in comparison with the rest of the globe, if we have had that information in the past week.

I know that there are constant staff pressures on the national health service at the moment, but do we have any indication of when screening services—for example, breast screening for over-70s—will be fully back up and running?

Humza Yousaf: You are right, of course, to couch that question in terms of those pressures. I hope that I am not speaking out of turn by saying that, in the conversations that my officials and I have had with health boards this week, many of them gave us the consistent message that they feel that this week is probably the toughest week that they have faced in the course of the pandemic.

We have not had today's numbers of those in hospital with Covid—they have not been published yet—but yesterday's number was just under 2,000, and we can add to that a high level of delayed discharge. Yesterday, I talked to the Glasgow health and social care partnership, which is unable to discharge people to care homes, given the scale of the outbreak. If we add to that staff absences and the accumulated pressure, it looks like this week is shaping up to be, if not the worst or most challenging week of the pandemic from a health service perspective, certainly one of the most challenging.

09:15

With regard to routine screening programmes, all adult screening programmes have resumed safely. However, although they have restarted, it is fair to say that they are playing catch-up in some respects. Breast cancer screening has restarted, and, of course, anybody with signs or symptoms of breast cancer should seek screening.

We have taken action to address our screening capacity challenges. On cervical screening, we are having to clinically prioritise higher-risk participants in non-routine pathways. Bowel cancer screening has resumed and new home testing kits have been sent out. That programme is generally operating in line with pre-Covid performance. The triple A—abdominal aortic aneurysm—screening has resumed, and men in the highest risk cohorts are being prioritised. Diabetic eye screening has resumed and is targeted towards those with the greatest risk of developing diabetic retinopathy. Therefore, screening has resumed, but there is clinical prioritisation, given the backlogs and capacity constraints.

Professor Leitch: For complete clarity, we do not routinely offer breast screening to women over 70. Routine breast screening stops at 70, but women over the age of 70 can self-refer, if they are worried. Self-referral just to the breast screening clinics was paused in order to prioritise in exactly the way that the cabinet secretary has described. That does not mean that women over 70 cannot access breast screening; they should do that by going to their general practitioner. If they have any worries about lumps, bumps or bleeding—anything at all—they should go to see their general practitioner.

Breast screening for women aged 50 to 70 is back and working at full capacity. Self-referral to breast screening buses and clinics has been paused for the over-70s, but we never did such screening routinely anyway—that was for people who wanted to self-refer. The route for that is presently through general practitioners.

Humza Yousaf: Having had a conversation yesterday with the screening team, I know that the position in Scotland is different from the position in, for example, England and Wales. Therefore, we are looking to see how we can quickly resume

the self-referral process. I hope to do that and to be able to say something more on that in the coming weeks. We must bear in mind that allowing self-referral for those aged 71 and over could cause slippage between screening cycles for those in the 50 to 70 category, but we might judge that the benefit of allowing that self-referral outweighs that risk. That is the conversation that we are having and which I had yesterday with the breast cancer screening team.

The Convener: That is helpful, because I have a constituent who is over 70 who has a history of breast cancer.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. Professor Leitch, I was glad that you mentioned *The Lancet* paper, which is a very interesting study that gives us quite a lot of reassurance about the choices that we have made about tackling Covid. Another interesting aspect of the paper is that it argues that there is no clear relationship between levels of excess mortality and the different levels of restrictions that have been applied; it puts the emphasis much more on vaccination. However, I suspect that we will have that debate later this morning.

I will go back to the committee's inquiry. We have taken a lot of evidence over the past few weeks on reduced access to services. At the core of many of the issues is the fact that people have not been able to see their GP or access basic screening. Cabinet secretary, do you agree that that has had an impact on patient outcomes? Are there particular parts of the patient pathway, such as primary care, that have been the major cause of problems leading to the current level of excess deaths and that will cause future excess deaths?

Humza Yousaf: Yes, I agree. It would be foolish not to agree with that statement. It is absolutely the case that the pandemic—I often describe it in these terms—is the biggest shock that our health service has faced in its existence. It is impossible for that not to have had an impact on access to services and, therefore, on outcomes for people's health and public health more generally. I have looked at the evidence that the committee has taken thus far, and clinicians and third sector organisations have given compelling evidence that people have not presented in the way that they would have done before the pandemic, which undoubtedly will have had an impact. There will have been an impact right across the country and right across the patient pathway, from diagnosis through to treatment and aftercare.

In asking your second question, which was about particular parts of the patient pathway, you referenced primary care. That is often the front door, as everybody round the table knows well, and the first port of call. Doctors, dentists and people across the range of primary care have been affected. I was at a surgery that Murdo Fraser probably knows well: the Taymount surgery—

Murdo Fraser: I am a patient there.

Humza Yousaf: I did not know that.

Murdo Fraser: I do not trouble it very much, to be fair.

Humza Yousaf: Patient confidentiality is clearly working very well, because I was not told that.

I was seeing Dr Shackles and some of the rest of the team at the Taymount surgery, and they have done exceptionally well. They are part of a group that also has a surgery in Scone, as Murdo Fraser will know. They told me that they have had challenges even though their surgery is a relatively large one. Other surgeries are much smaller, such as my medical practice, and their ability to see people face to face has been even more constrained. As we recover from the pandemic—we are recovering and will recover—we will need to look at a hybrid model, of which telephone consultations, video consultations and increasing face-to-face consultations must all be parts.

Dentistry has been hit really hard because of the nature of the aerosol-generating procedures that are undertaken and the infection prevention and control measures around that. Again, it is recovering, but that will take time, particularly as we continue to have the IPC measures in place.

Many of the patient pathways give me concern, but the one that gives me the most concern—I suspect that I am not alone in this among those who are round the table—is probably the cancer pathway. You heard, again, compelling evidence from a range of organisations that represent those with a variety of cancers. We have evidence that there are some 5,000 so-called missing cancer patients from 2020. During the first nine months of the pandemic, 2,681 patients were diagnosed with breast cancer, 1,958 patients were diagnosed with colorectal cancer and 3,287 patients were diagnosed with lung cancer. Those numbers are, respectively, 19 per cent, 25 per cent and 9 per cent lower than would have been expected in that period if Covid had not happened.

There are a range of pathways that I am concerned about, but cancer causes genuine concern, and that is why it is such a priority for the Government.

Murdo Fraser: Thank you for that very helpful response. Going back to the question of GPs, as I said, I am a patient at that GP practice, although fortunately they do not see me very often—

Humza Yousaf: They would say the same, I think.

Murdo Fraser: We are both happy. [*Laughter*.]

One issue that has come out of our inquiry is access to GPs. We heard from Dr Andrew Buist from the British Medical Association, who pushes back really strongly on the notion that people have not been able to access GPs, but we still hear that anecdotally from constituents. Is the position with GPs now back to where it should be or are we still facing challenges?

Humza Yousaf: I would like to see an increase in face-to-face consultations, but as part of a hybrid model. That is where I agree with Dr Buist, Dr Shackles and many others who represent GPs and GP services. I do not think that anybody, including anybody round the table, would suggest that GPs have not been working hard throughout the pandemic. They have.

We need to make improvements on data. I know that committee members asked questions about that during the inquiry. We are working on a project to get better data extraction from primary care. I have seen the first cut of that data extract, but it needs to be quality assured and so forth. I promise the committee that it will be published as soon as it has gone through that appropriate process. However, the first cut of the data is unsurprising in that it shows that GPs are working incredibly hard, but as part of a hybrid model.

I think that that hybrid model should remain. I contacted my GP a number of months ago, and it was much more convenient for me to be able to telephone, have a video consultation and pick up my eczema cream at the pharmacist. That saved me a journey to the GP's clinic and the time that would have been involved in that. We want to see an increase in face-to-face appointments, but as part of a hybrid model.

What Murdo Fraser hears anecdotally from his constituents and what I hear anecdotally from mine is also something that I hear from nurses in admission wards in acute hospitals, for example. There is more to do to increase the number of face-to-face appointments, but we have to recognise that GP practices are still operating under really difficult infection prevention and control conditions.

Alex Rowley (Mid Scotland and Fife) (Lab): Cabinet secretary, you made reference to the evidence that we have taken. Last week, Lawrence Cowan from Chest Heart & Stroke Scotland mentioned that the British Heart Foundation had done a study

"that showed that there have been significant increases in unhealthy behaviours, such as eating unhealthily and smoking, and an increase in isolation and loneliness."

That then went on to look at poverty specifically.

Peter Hastie, whom you mentioned, said:

"Health inequalities remain at the heart of everything that Macmillan Cancer Support wants to do. If a person lives in a deprived area in Scotland, they are more likely to get cancer, to be diagnosed later and to die. I cannot see how it would be possible for the pandemic to have improved that situation."

In the same evidence session, Rob Gowans also said:

"A number of things need to happen. We know that the number of excess deaths in the most deprived areas is twice what it is in the least deprived areas. We need better data and, in particular, data that is disaggregated by age, sex, race and other aspects"

of socioeconomic background. There is a question in that about the data that we are collecting, as well as a question about prioritising and focusing on the most deprived areas, and what we will do about that.

At the meeting, I asked Lawrence Cowan about joined-up working. I assume that we all agree that we do not see the NHS as being just about acute services; we know that there is a primary sector and a local authority sector. It is quite worrying that he said:

"At the moment, we are doing a lot of partnership working with health boards, which is really positive. However, we are doing the running on that and it should be an automatic system, so that when a patient is discharged from hospital, they are discharged automatically to a wealth of services. That happens in some areas, but not in others."—[*Official Report*, *COVID-19 Recovery Committee*, 10 March 2022; c 8, 10, 9, 9.]

I recognise the pressures that NHS services are under, but it seems to me that there is massive resource that we are not pulling together—that is, joined-up government. What is your view on that?

Humza Yousaf: Thank you for giving that important context to your comments and questions. I do not disagree with the notion that we could do even better in relation to integration. The third sector plays a massive role in that.

Not too many months ago, I was in a meeting on the issue of delayed discharges—I know that Alex Rowley has raised that issue on many occasions in committee and in the chamber. The local third sector interface was part of that conversation, and a number of people from the third sector said exactly what Lawrence Cowan said. They felt that they were having to be proactive. I have certainly communicated to health boards and local integration authorities that they should be using every single resource in the community that they possibly can.

Over the past two years, and in deprived communities in particular, our welfare rights and money advice services across 150 primary care settings, and our community link workers—probably all MSPs have a good relationship with our community link workers—have been vital in

helping to make those connections. However, I will be frank in saying why—a more detailed debate on what I will say is for another day—the national care service is so important. Social care is vital in helping us to deal with the pressures that we are facing, and it is under enormous pressure. However, we know that, if there is consistency of care throughout the country, that could make an important difference to the pressures that our NHS faces. I do not disagree with that.

Just last week, we published a really good piece of work by our primary care health inequalities short-life working group. Dr Carey Lunan, who is, I suspect, known to everybody in the committee, and some of her colleagues from the Scottish deep end project have done some brilliant work in that regard. I commend that piece of work to anybody who has not seen it.

09:30

Alex Rowley: I put to you the point that, although there is massive pressure on all resources, I believe there is a lot of resource out there. During last week's evidence session—and sessions before it, with Dr Buist and others—when we asked whether health and social care, and social work in GP practices, is working on the ground, the answer was that it is hit and miss. The issue is not just about resources; it is also about leadership and management. I would have thought that that must be about leadership from the top.

I had a look at a Public Health Scotland statistical report and at a Scottish Parliament Information Centre report, which said that the number of cancer deaths recorded as having taken place at home or a in non-institutional setting in the early months of the pandemic was substantially higher than those that took place in hospital. That trend seems to have continued.

In the NHS Fife area, the average number of daily occupied beds for palliative—hospice—support dropped from 20 down to nine, although 22 beds were available. The percentage drop in occupied beds was down from 86.3 per cent to 39.7 per cent.

Fife has the lowest number of occupied beds, by the way. I think that NHS Highland is next, with about 53 per cent occupied. What will be done about that massive drop? We know that some people want to stay at home when they are dying, but some families want a higher level of support and that seems to be missing.

Humza Yousaf: I am shortly due to meet NHS Fife, local government and the local health and social care partnership. Nicky Connor and her team at NHS Fife do an excellent job. I had very helpful conversations with them about delayed discharges last autumn and winter. We were going in the wrong direction, but we managed to pull that back. However, I am afraid that, because of the most recent wave of the pandemic, we have begun to go in the wrong direction again. I will consider the specifics of the question and raise those issues directly with NHS Fife.

We know of the pattern that Alex Rowley has mentioned in relation to palliative care, and we know that more deaths have occurred at home throughout the pandemic; further investigation is needed on that.

We have committed to producing a palliative care and end-of-life care strategy to ensure that people and their loved ones get the care and support that is right for them when they need it most. To help inform the strategy—because I think that some of the data could be more robust—the Scottish Centre for Administrative Data Research is already undertaking research to investigate home deaths during the pandemic. That work will help us to understand what strategy we should develop, so that we can understand more clearly the causes of the shift in place of death during the pandemic and whether that will be a long-term trend. If so, we need to ensure that the appropriate structures and, where necessary, the appropriate funding, are in place. That answers the more general part of the question, but I will take up the specifics with the appropriate partners in Fife, whom I am due to meet relatively soon.

Brian Whittle (South Scotland) (Con): I want to return to the issue of excess deaths. It was mentioned that most of those are due in part to Covid. If I remember correctly—I am sure that you will correct me if I am wrong—Covid is a contributing factor. For example, a high proportion of people—more than 60 per cent—of those who died of Covid, or whose deaths were Covid-related, were obese. For a third of deaths, diabetes was a factor.

Do we have an opportunity to reassess and reset how we deliver healthcare, and link that to factors that are outside of the NHS? I am talking about looking at the education system in the broadest sense. As Alex Rowley mentioned, there was a high incidence of Covid deaths among those in poverty. Do we have an opportunity, looking ahead, to reset healthcare? If you agree with that, how will the Government take up that opportunity?

Humza Yousaf: I agree with that. I acknowledge that Brian Whittle has a long-standing interest in that area and has advocated for a preventative model of healthcare. A preventative approach is incredibly important. Many years after the Christie commission, we invest heavily in that space, but we could definitely do more.

Education can play a role in prevention, as can social prescribing, which we are looking to expand. I mentioned the community link workers that we have in place. We have also committed to providing 1,000 additional mental health support workers, whom every GP practice in Scotland can access for assistance with social prescribing. The ability to do that is incredibly important.

Sport plays a huge role in that respect. I recently had a really good meeting with the Scottish Football Association on how we can use Scotland's most-loved sport, and the grass-roots network of football clubs across the country, more strategically to address some of our health aims as we move forward. We are doing a lot in that space, but there is plenty more that we could do.

Brian Whittle is correct to say that there is an opportunity, although it comes from tragic circumstances, to improve our public health outcomes.

Brian Whittle: I point out that it is not about sport for sport's sake—it is about education through sport and physical activity. I would rather use that phrase, because everybody thinks, when I talk about sport, that I want to make people run eight 400m laps. That is not quite where I am at—I would not attempt that myself.

Moving on from that aspect, I go back to the question of data. Perhaps it would interest the cabinet secretary to look back at the work that the Health and Sport Committee did in the previous session of Parliament on sport and social prescribing. The data is incredibly important, as Professor Leitch highlighted when he discussed the importance of global data.

A lot of the evidence that we have gathered, which has followed the committee through from the previous session, shows that there is a lack of co-ordination in relation to data collection. That will hamper our ability to plan ahead and to reassess—recreate, if you like—the way in which we deliver healthcare.

On top of that, we do not have an information technology system in the NHS that is fit for purpose. For example, the data does not follow the patient from primary care into secondary care, and it does not link up with the third sector. We need all of that to happen.

When we discuss IT platforms, it is incredibly boring, but they are an incredibly important first step. I do not know where the Government is with that.

Humza Yousaf: I actually find that incredibly interesting—perhaps I am in the minority, but it is genuinely interesting.

We have a lot—a plethora—of data. As cabinet secretary for health, I regularly get reams of data. However, is that data joined up in the way that I would want it to be? Absolutely not.

I commend to Brian Whittle—he may already have seen it—and to any member who has not seen it our recently published document, "Enabling, Connecting and Empowering: Care in the Digital Age—Scotland's Digital Health and Care Strategy", which is available online. I was looking at the strategy again as Brian Whittle was talking. On page 8, it lists three important aims. The second aim—I am paraphrasing the strategy—is to ensure that our health and care services have the important digital foundation that can allow access to, and the ability to share, relevant information across health and care systems. Care is a really important part of that, too.

This is not necessarily about uprooting every digital system that we have—that way of thinking could almost be described as old school. Instead, on page 18 of the strategy, we go into more detail about how we create the cloud infrastructure that will allow data sharing to happen. We do not have to upend every element of our digital IT infrastructure in primary care, various health boards and so on; we just have to create the cloud infrastructure that will allow greater sharing of data.

We have got to do that, but how do we do it with the third sector and those who are external to health and care? My direction to my digital team—the approach goes across Government, too—is that, while obviously being mindful of and aligning with various frameworks and obligations around data, including data protection, we should not be putting up any artificial barriers to sharing data with the third sector, where that is appropriate. We still have work to do on that, but I would commend the digital health and care strategy to those who have not had a chance to look at it, as it goes into a fair bit of detail about our ambitions in that regard.

Brian Whittle: I should probably declare an interest at this point, as I was a director of a healthcare tech company that worked on collaboration and communication platforms before I became an MSP.

The technology in question is not new and is available. On your point about not having to reset everything, I would say that we need to be able to suck data into a central platform, allow those data to talk to each other and then see how we can use the output. As we discussed the last time that you were here, I am suggesting that we do not have an IT system that can do that at the moment. If we are to move forward, that issue needs to be addressed, and I am happy to discuss that with you offline.

Humza Yousaf: I am happy to do that. Again, though, I would highlight page 18 of the strategy, which refers to a national digital platform. As you have rightly pointed out, we are not talking about a single product but about a collaborative and integrated approach to delivering cloud-based digital components that will allow us to share data in a way that we might not have been able to thus far. I am certainly more than happy to have that discussion offline, Mr Whittle, if you wish.

John Mason (Glasgow Shettleston) (SNP): We have already touched on a number of issues, but I just note—this has been said already—that this week has perhaps been one of the worst that we have had, and the hospitals seem to be absolutely full. However, evidence that we have received suggests that non-Covid conditions have really suffered over the past two years. Should our focus now move from Covid to non-Covid conditions? Has that already happened or is it still to happen?

Humza Yousaf: Jason Leitch might want to respond to that, too, but I do not see and have never seen such things in a binary way. For example, a number of people who are in hospital with Covid might have been admitted for other reasons and have caught Covid while there, and we know that Covid can exacerbate underlying health conditions such as respiratory problems and diabetes. I do not think that we can say, "Let's stop focusing on Covid and start focusing on other conditions."

It is also true to say that the pressures that we are facing will diminish significantly when we are able to control Covid. Although 2,000 Covid patients might in the grand scheme of things seem like a small enough number, given how many beds that we have in our hospitals, the IPC that goes around those patients puts significant pressure on the health service. With community transmission as high as it is at the moment, levels of staff absence in our health and social care system will tend to be higher, and there has also been an increase in delayed discharges, because, as I have mentioned, our ability to discharge people into care homes has been severely diminished as a result of the increase in outbreaks. Controlling Covid will therefore be essential in helping us recover with regard to the non-Covid conditions that John Mason has mentioned.

At the same time, though, we are focusing on those very conditions. Before I became health secretary, we had the cancer plan, which was backed by £114.5 million; when I came into post, the early cancer diagnostic centres were being rolled out; and we have recently launched the "Endoscopy and Urology Diagnostic: Recovery and Renewal Plan". We are looking to recover our position with regard to non-Covid conditions, but I do not see it as a binary choice of focusing on one thing or shifting the focus to something else.

09:45

We know that this probably will not be the last wave of Covid, or even the last period of concern in relation to Covid. The real challenge is how, when we have waves, we protect the diagnosis and treatment of non-Covid conditions, including carrying out elective surgery and unscheduled care, while managing and treating Covid. We have not been able to crack the answer to that yet. Part of the answer must be some of our work in and around the hospital at home programme, which includes a treatment pathway for Covid. Another part is about how we treat people with antivirals at home as opposed to admitting them to hospital.

There was a lot in that. I do not know whether Jason—

John Mason: Before going to Jason Leitch, I would like to pick up one point. You have talked about staff absences. Clearly, that has been a problem for the health service and elsewhere. With the rules changes in the coming weeks, will there be less need for isolation? I assume that some of the staff absences are people who have either tested positive but have no symptoms, or whose family members have tested positive and who must stay at home. Do you anticipate the situation improving in the short term?

Humza Yousaf: You will remember that one of the things that the First Minister made clear in her announcement is that testing for health and social care staff will remain, including the testing of asymptomatic individuals; that will not change.

As we move from the transition phase to the steady state, might that have an impact on staff absences? Potentially, but the biggest impact will be if we can control transmission. The more that we can control community transmission, the more impact that will have on staff absences.

The general number of staff absences sometimes masks the detail. If we look at staff absences that are not just related to Covid but related to those who are testing positive themselves, we find that we have unfortunately seen rises in the past few weeks—that is the case in the community, too—which have exacerbated the pressure that we were already feeling.

Professor Leitch: One advantage of opening up a little is that I have been able to get back to meeting people in the health and social care system, although I am not sure whether those in the health and social care system think that that is an advantage. I spent the beginning of this week in Tayside and Grampian, meeting and thanking those who have led us through the pandemic. It is

not as straightforward as moving from Covid to non-Covid, although I wish that it were; I wish that we could switch off the pandemic.

The cabinet secretary is right. The fundamental change is that we need to get prevalence down. With the eye of faith, the rate might be beginning to flatten just a little. We are a few weeks behind Northern Ireland, which is on a downward slope. We have no reason to believe that we will be any different. England and Wales are on an upward slope, and are a bit behind us. I think that they will have exactly the same pattern with B.A2 as we have had.

I saw health and social care staff and third sector organisations working hard to fix, frankly, anything that turns up, but Covid makes all that more complicated. We do not want Covid to spread from one individual to a four-bedded bay in Ninewells hospital, which is 50 years old. Some of the estate in Grampian where patients must be cohorted if they test positive or their contacts test positive is much older than that.

Covid makes hand surgery more difficult, even if that is not to do with the surgery itself. I mention that because I happened to meet some hand surgery patients when I was visiting. Everything is about getting down the prevalence of this infectious disease. That would be true if it were norovirus or if it were flu—it is just that we have a new version to deal with.

I saw encouraging signs of pressure beginning to come off services, particularly in critical care, which is kind of back to its normal footprint. When I last visited, the unit was three times as big; now it is back to its normal size. The unit is full, but it is full of patients requiring post-op care, those who have had strokes and the occasional Covid patient. It definitely feels different. The clinical teams are transitioning to that more common way of working. However, we do not have slack in the system.

The only other thing that I would add is that staff are tired. They are looking forward to time off at Easter or during summer, because many of them have worked for two and half years without a break. We need to be careful not to overload an already fragile community that has saved tens of thousands of lives over the past two years.

The staff who I met were enthusiastic; they were still smiling, although maybe I met only that type of staff. They were terrific. However, I was conscious of our having asked a lot of them. I met a care home manager who, in a previous wave, slept in her care home for three weeks after there had been seven deaths in the home. She is keen to keep going, but we have to give people time to recover.

John Mason: In response to Murdo Fraser's question, dentistry and a few other things were mentioned. Clearly, recovery is different across the board. I have not seen my dentist for more than two years. I have chipped my teeth during that time but, fortunately, that has not caused me a lot of pain. Where are we going with dentistry? How soon can we get back to six-monthly appointments? Is that entirely up to individual practices? I dislike the idea of going to a private dentist, but is that the advice in order to take pressure off the NHS?

Humza Yousaf: No, we are not giving that advice. There is no doubt that the dentistry sector has been hit hard, for all the reasons that I gave to Murdo Fraser, particularly given the aerosol-generating procedures that dentists have to carry out. However, dental practices are opening up and are taking the appropriate precautions. We have provided dental practices with support and grant funding for ventilation and for drills that can be used to mitigate the effects of aerosol-generating procedures.

Through what is in essence a multiplier, we will reward dentists who do more NHS activity. We had a good debate about dentistry in the Parliament recently. I am sure that this is happening only in a minority of cases, but we heard some concerning stories of dentists upselling private plans to their patients. That is, of course, not allowed within the regulations, but it is also deeply unethical. Through our funding arrangements, we will reward dentists who see more NHS patients.

We will recover, but I cannot give an exact date for when the recovery will be complete because, as we have discussed, we are still in the midst of the pandemic. Until we get to pre-pandemic levels of activity, I am afraid that the backlog will continue to increase. That is true across the health service. Only when we get to pre-Covid levels—or, I hope, above pre-Covid levels—will the backlog begin to reduce. Given that we are still in the midst of a global pandemic, it is difficult to give a definitive date for when we think the recovery will be complete.

John Mason: More constituents have been on at me about not having access to a dentist than have been on at me about not having access to a GP or probably any other service. We say to people that, if they cannot get a dentist in Baillieston, for example, they should try ones in Shettleston, but they say that they have tried all the dentists in the area and that none of them will take them. What should I say to those constituents?

Humza Yousaf: You should say that, through the Government's funding arrangements, we will see a step change. I am certain of that. Dentists

will still have to operate within the IPC constraints, so they will not be able to see as many people as they saw before the pandemic. Before omicron, activity levels in dental practices were beginning to rise, and as a result of the new funding arrangements that incentivise and reward NHS activity, those levels will rise even more.

It might be worth asking Professor Leitch whether he has anything to add, given his expertise in dentistry.

Professor Leitch: Dentistry is one of the best examples of why the situation is so hard, because dental procedures pose a particular Covid risk to patients. Earlier this week, I went to the dental school in Dundee and met new students, who are working in an entirely different environment, with little pods being used so that we can protect them and patients during AGPs. I met a patient who had been coming to that dental hospital for check-ups every year since 1964, and he was on his 40th student. That was fantastic. The students were full of enthusiasm, but they were working within the constraints that we have set for them.

This is slightly easier for an adviser to say than it is for a politician: dentistry and optometry use a mixed model in this country. Such services are not free at the point of delivery for every member of the population. Governments have made that decision for 70 years. However, if an NHS patient wants NHS treatment, that should be available to them. That is not the same as saying that private care is not available. There are also independent providers as well as very expensive private providers.

There are three layers of dental funding: there is the NHS layer; the insurance system, which a lot of people use and that might involve someone paying £25 a month to get X care; and the high-end private providers in Harley Street and in Glasgow and Edinburgh. That mixed model is available to people, but the NHS model, which has had to adapt in the past two years, is now coming back. My colleagues say that they are beginning to see an increase. That is partly because the tech has changed and we are now able to give them new technology, and because the funding streams are now adjusted.

My advice to your constituents would be to be just a little bit more patient. If the issue does not fix itself within the next six months, they should come back and ask again.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I want to go back to Murdo Fraser's original question about access to GPs and the hybrid model. Last week, I asked our witnesses whether we should give people the understanding that the hybrid model will be the way in which they see their GP in future. One response that I found interesting—I apologise, but I cannot remember the name of the lady who said it—was that it would very much depend on how the patients accept it, or words to that effect.

You say that we are going to proceed with the hybrid model. Does the Scottish Government have to do a messaging job to get people to understand that? How will you put people's minds at ease about how they will be seen going forward?

Humza Yousaf: There is a need for communication. I think that it was Dr Shackles who said that there needs to be an open and honest conversation with the public. If it was not Dr Shackles, I will be happy to correct the record, but one of the clinicians who gave evidence to the committee talked about having an open and honest conversation. I hear that from clinicians day in and day out, time and again, and I do my best to be up front about the fact that the recovery will not take just weeks or months—it will take years. People are now coming to accept that, and the reasons for it.

I should say that we had a hybrid model before the pandemic. People were able use telephone and video consultations, but those were being used nowhere near to the scale that they were used during the pandemic.

There is a balance to be struck. My direction, which is spelled out in the recovery plan, is to increase face-to-face access to GPs, because we know that there are possible issues with digital exclusion and we must work hard to narrow that exclusion and eliminate it altogether. I hope that I am not overgeneralising, but we know that some of the older constituents that we represent might want to see their GP face to face, and it is important that, when people wish to see their GP face to face, and when it is clinically appropriate, it should happen.

However, we must also continue to invest in telephone and video consultation facilities. To go back to the question that Brian Whittle asked, there is something about how we access the NHS and health and social care through digital that is going to increase. There are good pilots that show how we are doing that, and we probably need to upscale those.

Jim Fairlie: I know that this is an inquiry into excess deaths but, as you said, staff are exhausted. A recurring theme that we have seen is GPs feeling as though they are being blamed for a lot of the early diagnoses not happening and for a lot of the problems that we have seen as a result of Covid. GPs are feeling a lot of the pressure of that. We need to rebuild trust and a relationship with the public.

Last week, we were told that some GPs are being incentivised to retire earlier than they might

have done because of the existing pensions and tax arrangements. I know that I am going off piste here a wee bittie, but we cannot deliver good healthcare if we do not have comfortable well-paid staff who want to be there and want to do the best that they can. If they are not enjoying the job any more, the healthcare system will suffer.

We can go through the situation for all staff, such as nurses, porters and doctors, but the specific issue of GP retirement was raised with the committee. I know that the Scottish Government has looked at that, and that you have spoken to the UK Government about it previously. What progress have you made? Has anything happened with regard to not incentivising GPs to retire earlier?

10:00

Humza Yousaf: I have a few points on that. There has not been any progress on the matter that I raised with the UK Government. I always thought that it would be a long shot, given the financial pressures that everybody is under. That said, I will continue to pursue the issue to see where pension changes could be made, if it is possible, to help with retention. I have given the BMA a commitment on that.

The BMA has rightly challenged the Scottish Government and asked what more we can do in this space. For example, it has asked me to give active consideration to a recycling employer contributions scheme, and to giving health boards the ability to activate such a scheme if it would be in their interest to do so. As I said, that is, and continues to be, under active consideration.

However, I go back to the point that Jason Leitch made. Of course we have to deal with any financial disincentives that might be in the system. However, if we can control Covid—or rather when we control it, because we will—and begin to recover in stages, in a managed way, we have to do so in a way that does not exhaust a workforce that is, to be frank, already knackered.

In a GP practice, that is not just the GP alone—although, of course, they will be knackered. It is the multidisciplinary team, including the receptionist, who will always be the first person that people talk to. Receptionists tell me that they have experienced an increase in abuse over the phone and in person, so we need to ensure that they and their wellbeing are well taken care of. We have invested record levels in the wellbeing of NHS and social care staff, and we will continue to do so.

We will do what we can to rid the system of financial disincentives, and we will actively consider that issue. We will ensure that staff are well paid. As you would expect me to do, I reiterate that we have the best-paid NHS staff in the UK. We will also ensure that we do what we can to retain staff. There is a whole section in the recently published workforce strategy on nurture—in fact, it is a thread throughout the entire strategy—which looks at what needs to be in place for the wellbeing and retention of staff in order to help with recovery.

Professor Leitch: That issue has been a challenge for health service employees at the higher end, in salary terms, for years now. It affects not only dentists and doctors in particular, but some healthcare managers who are in the NHS pension scheme. The issue has been a matter of controversy between the devolved Administrations and the UK Government, and the cabinet secretary continues to make the point in meetings. It needs resolved, and the BMA has been forceful in asking the UK Government—principally, because much of the power is reserved—to resolve it, while also asking the other three Governments to do what they can.

It is quite a hard message to sell to the highest-paid members of our service, but the other option is that they will leave and retire at 57, and we really need them to stay. It is about lifetime allowance, and people coming back and effectively working for free because they have to pay 70 or 80 per cent tax on what they continue to earn. I know that there are some around the country who will not have a huge amount of sympathy for those on that level of pay, but we need to retain them.

Jim Fairlie: I understand that there might not be a huge amount of sympathy, but it takes 10 years to get a GP up to that standard, and we do not want them leaving the service 10 years sooner than they might otherwise have done.

Professor Leitch: And they may be the GP on Barra or in Elgin, where it is very difficult to recruit, so I agree with you.

The Convener: I am conscious that the cabinet secretary has to leave at 10:15, but I will bring in Murdo Fraser, followed by Alex Rowley.

Murdo Fraser: I want to pick up on the issue of emergency medicine, which we have not touched on much this morning. Some of the most striking evidence that the committee heard was from the Royal College of Emergency Medicine, which told us that, in 2021, there were 500 excess deaths related to people accessing emergency treatment too late. That is 10 people per week dying because the ambulance does not turn up on time or because, although the ambulance turns up on time, when it gets to the hospital, it cannot get its patients out into the emergency ward in time. That was really striking.

The royal college highlighted the continuing lack of capacity in the workforce. On Friday, you announced a new national workforce strategy, and I was interested to see the comment that the royal college made to the press on that yesterday. Although it welcomed the strategy, it said that it was

"disappointed … not to have been consulted"

on it

"and by the limited mentions of Urgent and Emergency Care."

Will you meet the royal college to discuss that and take on board its real concerns on the matter?

Humza Yousaf: Yes, I will. I am somewhat surprised by the comment, because I meet the Royal College of Emergency Medicine regularly. I think that Dr Thomson gave evidence to you. I have met him in the past, and those meetings helped to inform our strategy. No doubt, that is why he welcomed it. A lot of the issues that he raised with me are core components of it. Of course, as we say in the strategy, it is an iterative document that will continue to develop and evolve as we make our way through the pandemic and into recovery.

Of course, I will meet the RCEM, as I do regularly. We consulted a number of stakeholders. I take on board what the RCEM said yesterday. The royal college can be assured that I am keen to meet with it early doors to get its further thoughts on our workforce strategy.

Murdo Fraser: Will you give us a sense of where we are now on the delays with ambulances? Clearly, there is a lot of pressure on NHS emergency wards. Are those issues still happening?

Humza Yousaf: Yes. That goes back to what I said. I am happy to state on the record that, in the conversations that health boards have had with me and my officials this week, they have said to us that this feels as though it could be the worst week of the pandemic—or, if not the worst, certainly among the worst weeks. There is an accumulation of factors that I have already spoken about.

Yesterday, I met Pauline Howie and Tom Steele, the chief executive and chair of the Scottish Ambulance Service, and they said again that they are under severe pressure. We know the knock-on effects—I will not go into detail on them. In fact, from my reading of previous evidence sessions, I know that Murdo Fraser has previously raised the issue of ambulance waiting times and turnaround times at hospitals.

We are seeing those pressures play out this week. My hope—it is not just a hope; we are working to do this—is that we will alleviate as much of that pressure as we possibly can while realising that, as Professor Leitch says, we will get through the peak that we are currently at. The question is how we will insulate our health services, including emergency medicine, when we have a future peak. We are working as hard as we possibly can on that. However, it is a challenging time at the moment.

Alex Rowley: I will ask a question about the redesign of urgent care. I read an article this morning that suggested that £40 million had been spent on that but the results were not great, so you have now commissioned consultants at a cost of £84,180 to review that redesign. Where is that work at, and what is working and not working?

Humza Yousaf: There have been some positives on the redesign of urgent care. If any programme has been needed during the pandemic and is needed into recovery, it is the redesign of urgent care. It is not unusual for the Government to take feedback on what areas of any programme can be improved and to take advice on whether it needs to be readjusted.

We are implementing the redesign of urgent care programme, which is supported by significant investment. For example, a hub has been established in every health board to directly receive referrals from NHS 24, offering rapid access to senior clinicians and using telephone or video consultation, where possible, which minimises the need for people to attend A and E.

There has been good innovation, but we are never against seeing how we can improve programmes, including the redesign of urgent care.

Alex Rowley: You have spent £40 million on it. Is it delivering the results that the Government expected?

Humza Yousaf: We have certainly seen a positive impact, although it is difficult to judge that during the pandemic. The redesign of urgent care programme will be vital to our recovery, as we will have to reduce the demand on acute care. The redesign of urgent care will help with that, as will the hospital at home work that we are doing. Addressing the issues on social care that Alex Rowley raised will also help with it.

We will have to reduce the demand. The redesign of urgent care programme has helped to an extent, but I have no doubt that we should consider what additional improvements could be made to it.

The Convener: That concludes our consideration of this agenda item and our time with the cabinet secretary. I thank him and his supporting official for attending.

I suspend the meeting briefly to allow a changeover of witnesses.

10:12

Meeting suspended.

10:19

On resuming—

Ministerial Statement and Subordinate Legislation

Coronavirus (Scotland) Acts (Amendment of Expiry Dates) Regulations 2022 [Draft]

Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2022 (SSI 2022/64)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 3) Regulations 2022 (SSI 2022/53)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 5) Regulations 2022 (SSI 2022/74)

The Convener: I welcome the Deputy First Minister and his supporting officials, Professor Jason Leitch, the national clinical director; Greig Walker, the Coronavirus (Recovery and Reform) (Scotland) Bill team leader; Elizabeth Blair, the unit head for Covid co-ordination; and Stewart Cunningham, a Scottish Government lawyer, who joins us online.

As members will have seen, following the First Minister's statement on Tuesday, the Minister for Parliamentary Business has written to the committee. In his letter, the minister explains which legislation the Scottish Government is revoking in the light of the statement. I draw the letter to members' attention, as those changes affect the secondary legislation on our agenda.

I invite the Deputy First Minister to make some brief opening remarks before we move to questions.

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

As the First Minister set out on Tuesday, there has been a recent increase in cases driven by the BA.2 sub-lineage of the omicron variant. It is now the dominant strain in Scotland and accounts for more than 80 per cent of all reported cases.

Encouragingly, there is no evidence that BA.2 causes more severe illness than BA.1 or that it is more effective at evading natural immunity or immunity through vaccination. We continue to observe strong evidence that the link between infection and serious health harm has weakened

considerably due to immune protection. Therefore, extension of the vaccination programme is on-going, in line with Joint Committee on Vaccination and Immunisation advice.

Letters inviting five to 11-year-olds who are not in higher-risk groups for vaccination started arriving at the end of last week. Booster jags for older adults in care homes also started last week. Additional boosters for those who are immunosuppressed will start from mid-April.

As the First Minister announced, from Friday, and in line with other UK nations, all remaining Covid-related travel restrictions in Scotland will be lifted. Although we have some concerns about that, UK travel patterns mean that diverging from the rest of the UK would cause economic disadvantage without delivering any meaningful public health benefit.

From Monday 21 March—with one temporary exception—the remaining domestic legal measures will be lifted and replaced with appropriate guidance. That means that, on Monday, the requirement on businesses and service providers to retain customer contact details will end. So, too, will the requirement for businesses, places of worship and service providers to have regard to Scottish Government guidance on Covid and to take the reasonably practicable measures that are set out in the guidance. The exception relates to the requirement to wear face coverings on public transport and in certain indoor settings.

Given the current spike in case numbers, continued widespread use of face coverings will provide some additional protection, particularly for the most vulnerable, at a time when the risk of infection is very high, and it may help us to get over the spike more quickly. We will review it again in two weeks' time.

The other issue that the First Minister covered on Tuesday was testing. For the next month, until Easter, there will be no change to our testing advice. However, from 18 April, with the exception of health and care settings, we will no longer advise people without symptoms to test twice weekly. From the end of April, all routine population-wide testing will end, and, from 1 May, instead of a population-wide approach, we will use testing on a targeted basis. That marks steady progress back towards normal life and a more sustainable way of managing the virus.

We will do everything we can to support those who have worked on the testing programme during the transition. I echo the First Minister's gratitude and thank all of them for their invaluable contribution over the past two years.

I am happy to answer questions from the committee.

The Convener: Thank you, Deputy First Minister.

I will ask the first question. With numbers still high in Scotland—the Cabinet Secretary for Health and Social Care told us that this week could be one of the worst weeks from the point of view of pressure on the NHS—and concerns being raised in relation to the reduction in funding for certain Covid-19-related studies and data collection exercises from the end of March, including the ZOE Covid symptom study and the SARS-CoV-2 immunity and reinfection evaluation, or SIREN, and Vivaldi studies, which monitor infections in health workers and in care homes, Dr Stephen Griffin, who is a virologist at the University of Leeds, said that the decisions by the UK Government on Covid surveillance would

"slow the country's ability to respond and adjust to future waves or surges of infection"

or new variants.

Deputy First Minister, do you feel comfortable with the UK Government's current approach?

John Swinney: The issue is a challenging and sensitive one, and I will invite Professor Leitch to add some comments to my initial remarks.

To ensure that we have knowledge of the emerging situation, we must have adequate surveillance measures in place at two levels. First, we must have such measures in place at a population-wide level. It would be difficult to justify on a persistent, long-term basis the type of intense testing arrangements that we have had in place at a population-wide level, but we need to have some population-wide information. We believe that a high-quality Office for National Statistics infection survey, combined with the data that we collect from waste water, for example, gives us a sufficiently strong base of information at a population-wide level to be able to assess what I might describe as the generality of the position on the prevalence of Covid in our society.

The second important element is our contribution—which is the same as the contribution of other countries around the globe—to developing the detection, understanding and appreciation of any new variants that may emerge. We must be able to continue to do a sufficient level of testing in the population to enable us to identify any variants that are emerging, in the way that the testing approach that was taken in southern Africa identified the omicron variant, which was then identified in a number of other jurisdictions very quickly. We were alerted to that and were able to respond swiftly.

That matters because, as I have rehearsed with the committee before, we took decisions very quickly to tackle the situation that we faced in

relation to omicron. I am pretty certain that, if we had not done so, the national health service would have got into very deep difficulties. We averted that because of the speed of our actions. I know that our actions were controversial and that they did not command universal support, but the alternative would have been seeing our national health service overtopped. Intelligence about new variants is critical in enabling Governments to respond appropriately.

I do not know whether Professor Leitch wants to add to that.

Professor Leitch: The convener's question is crucial, and it allows me to deflect between advice and solutions. We have given very strong advice that the UK as a whole needs to continue to do three things. It needs to do surveillance—the Deputy First Minister has described that—and that surveillance has to include genetic testing. It needs to do research on the course of the disease. That is what SIREN has done for us. For those of you who do not know, in SIREN, health and social care workers who get the disease are followed over a long period to check their immunity and long Covid status.

We need to continue to monitor the course of the disease and treatment for the disease, which is what the randomised evaluation of Covid-19 therapy, or RECOVERY, and platform adaptive trial of novel antivirals for early treatment of Covid-19 in the community, or PANORAMIC, studies have done. PANORAMIC in particular relies on testing of the population. A person needs to know whether they are positive or negative to join the study. If we stop testing, PANORAMIC will have to find a new way of finding patients in order to enrol them to get the treatment and see whether it works.

From a public health perspective, we require to continue to do those three things, and the world requires to continue to do those three things. That will evolve over time. We do not do flu testing when people brush their teeth. We have to change the approach over time, but we need to continue to do those three things. We will give advice, as we have done, to the Deputy First Minister and others, as we have to the UK Government, that we need to continue to do those three things for us to help the population to live with the disease.

The Convener: My other question relates to test and protect staff who have been working for the past 18 months and have been in touch with me in the past couple of days. They feel that the announcement last Tuesday was a kick in the teeth. Forgive me if this is wrong information, but the information that was relayed from them was that the health boards told them that funding was in place for test and protect until September. Therefore, there was an assumption that they would be in the roles until September and not out of a job in April. Can you give any clarity on that and the funding options?

John Swinney: There will always be judgments to be made about the longevity of the testing arrangements. Obviously, there is financial provision in the budget for 2022-23 that enables some testing activity to be undertaken. I would have to clarify what specific guidance on that point was previously given to health boards, because that relates to an internal health portfolio transaction and advice, so I had better write to the committee about that specific point.

That said, I would not imagine that it was likely that commitments were given to that extent or to that degree of specificity. There might have been a commitment in respect of, say, the need for on-going testing—I would not be at all surprised by that—but I will check and write back to you to provide clarity on the point.

The Convener: Thank you—I would appreciate that.

10:30

Murdo Fraser: Good morning, cabinet secretary and colleagues.

I have a couple of questions about the vaccination programme. Earlier, Professor Leitch mentioned the recent report in *The Lancet*, which was very significant in highlighting the importance of the programme in suppressing the virus. However, a report in *The Scotsman* this morning states that 27,000 doses of the vaccine were thrown away in February after fewer people than expected came forward to be vaccinated. Is that report accurate? If so, should we be concerned about it? Are we seeing a drop-off in the number of people coming forward for vaccination?

John Swinney: There will always be a degree of waste—I suppose that there is no better word for it—in the vaccination programme. I think that we all accept that, and ministers have made it very clear that we want to minimise that. If memory serves, I think that the vaccination programme commenced with an assumption that there might be as much as 5 per cent waste, but the practical reality is that, throughout the programme, there has been less than 1 per cent waste. If it is a question of performance against expectation, I think that we would have to say that that was a very good performance.

I would have to check the detail of the newspaper report that you referred to, but we are endeavouring to maximise participation in the vaccination programme. We are doing that because vaccination is absolutely the key to minimising the harm of Covid. One thing that

concerns me about the narrative with regard to the discussion in recent weeks about Covid—particularly omicron—is the suggestion that omicron has been milder than previous variants. I think that that is the wrong way to look at the issue. I think that the vaccination programme is giving a lot more protection from what happens to be called omicron. There are numerous cases of people with the omicron variant who have faced very severe health consequences, because they have been unvaccinated.

We have to be careful about undervaluing the impact of the vaccination programme, as it has been crucial in tackling the effect of Covid, whether that be omicron or whatever. Fellow citizens of ours are having a very hard time with omicron—in many cases, that is because they are unvaccinated. The strength of the arguments in support of vaccination is, in my view, absolutely overwhelming, and the Government is using those arguments to encourage uptake of vaccination.

The more we have a sense that the worst of Covid is past us, the more there might be a sense that people do not need to get vaccinated. I would take entirely the opposite view and say that it is vaccination that is giving us the protection against Covid that people need.

Professor Leitch: Exactly as you would expect, Mr Fraser, I am going to take your 27,000 and raise it by the number of vaccinations that have actually been done.

For some context, I point out that, in January, we gave 472,000 doses and, in February, we gave 184,000 doses. Once the Pfizer vial is taken out of the freezer, it has to be used within 12 hours or thrown away. As the numbers go down a little and we get some of the stragglers instead of the 75,000 a day whom we were doing before Christmas, we will inevitably end up with some marginal differences, particularly in small vaccination centres where not all the doses can be used.

At the beginning, we said 5 per cent. We are still way below that. Nobody—particularly the vaccinators—wants to throw out any vaccine. That indicates that we are in a phase in which we are dealing with a group that is slightly harder to persuade to come to be vaccinated. We have vaccinated the massive bulk of people. As we deal with the over-75s, who are a big chunk again, and the youngsters, who are another big chunk, I anticipate that that waste will fall even further.

Murdo Fraser: The top line of the story in *The Scotsman* this morning was that fewer people than expected have come forward for vaccination. Is that correct?

Professor Leitch: No. I do not think that that is fair. I think that that is an extrapolation from a piece of data on waste. We do not take vaccines out of the freezer unless we know that there are people in the room. If you have got one or two people, you have to take the vial out of the freezer and it has to defrost, so you have got to think about that before people come. If you have appointments for 100 people, you might take out enough vials for 100 people, but then only 80 people might turn up. If you multiply that over a month, you get to 27,000 relatively quickly, because there are six doses in a vial.

I do not think that we have seen levels dropping off more than we thought that they would. We always knew that we would see a drop off after the big push for new year. That does not mean that I do not want everybody to come forward to be vaccinated.

Murdo Fraser: I have a specific follow-up question that arises from the case of one of my constituents who had quite a serious adverse reaction to the second dose of the vaccine. I know that that is rare, but it does happen. He then went to his GP, who advised him not to get the booster. His concern was that, if he was required at some point in the future to provide certification of full vaccination status, he would need to get an exemption. He then applied for an exemption, but he was told that he was not eligible. However, nobody spoke to his GP and nobody asked to see his medical records. He is now in limbo, because his GP has told him that he should not get a booster, but he is not entitled to an exemption. Where does he go from here?

John Swinney: Ministers have made clear to the Parliament on countless occasions that you can write to me about certification issues. Mr Fraser is welcome to write to me, and I will see that there is a resolution to that particular issue.

Murdo Fraser: I did write to you, Mr Swinney, and I got your reply last month. You gave me two pages of very general advice. However, that did not address the specific issue that that man's GP has told him not to get a booster at the same time that the NHS, without asking to look at his medical records, has told him, "Sorry, you are not eligible for an exemption." I am slightly confused about how somebody can reach that conclusion about his personal circumstances without liaising with his GP.

John Swinney: I am happy to look at that to see exactly how that can be resolved. We sometimes face competing medical opinions about the right thing to do. I will not give clinical advice, but I will ensure that the issue can be addressed.

Murdo Fraser: Okay. I will write to you again. Thank you.

On the entirely different topic of care homes, restrictions on visiting care homes have been

lifted, which is very welcome. A constituent contacted me to say that she has an elderly relative in a care home in which, if a member of staff tests positive, the entire care home is locked down and residents are not allowed to leave their rooms to go into common areas. That is very distressing for residents who have already had to put up with two years of isolation, and that happens with some frequency because of the high incidence of Covid. As far as I can tell, that approach is not set out in Government regulations, but it would be helpful if you could confirm that and say whether any advice is being offered to care home operators on such issues.

Professor Leitch: That is not the Government guidance, although quite a lot of risk assessment is done by care homes, which all look very different. Some are Georgian houses and some are very modern establishments, so we have to be generic and give some power to care home managers to make those choices.

If you contact us about that specific care home, I will ensure that somebody gets in touch to make sure that the managers are familiar with the most recent guidance. In light of the announcements on Tuesday, particularly around testing for staff and residents, the guidance will be redone. We hope that that will allow a further relaxation of some of the protections.

Those are our most vulnerable citizens, so we must be cautious but, as you have illustrated, other harms result from being locked in rooms and not being able to use communal facilities if someone tests positive. We are hoping to relax some of that.

That individual care home is not following the national guidance, but there might be good reason for that, such as its environment. Let us get in touch with it to make sure that we are doing all that we can for it.

Alex Rowley: I agree with the Deputy First Minister about the testing staff. I have been for a few tests in winter weather in Dunfermline and Cowdenbeath, and those people have worked through it all. They deserve our gratitude and thanks.

Given that we are going to scale back that work, how many staff are involved? Is the Government saying that health boards should start to look at a programme that will give people opportunity? We know that we have staffing shortages throughout the economy, and we certainly have tonnes of shortages in social care and the NHS. Are opportunities being put in place? Is there a programme for working with people who have given their all during the past year or two and getting them into other posts? Is there a plan in place for that?

John Swinney: The testing programme has been delivered through a number of channels. Some testing is delivered under the auspices of the NHS in Scotland, and some is delivered within the test and protect infrastructure that was put in place by the UK Government and its contractors.

There are different employment relationships in there. For example, the NHS in Scotland turned over substantial proportions of its lab testing environment for the purposes of Covid. There will be ways in which that will be redeployed for other purposes. There are therefore different ways of approaching the matter.

The key point—this is where I agree with Mr Rowley, and I want to reassure him—is that we have staff shortages in a range of areas within the health and social care system. Individuals who have been involved in testing have also been involved in that activity, so it would seem natural to make sure that they have access to recruitment opportunities within the NHS, as well as appropriate training opportunities. That will be taken forward by individual health boards, all of which have in place recruitment strategies to fill vacancies at different levels of activity in the health service.

Alex Rowley: That leads me to my next question, which I also asked the Cabinet Secretary for Health and Social Care. In the past couple of weeks, we have taken evidence from third sector organisations that have said that joined-up working can be a bit hit or miss. Some health authorities welcome those organisations and they have an input, but others have to wait until they are called upon. It seems to me that there is a massive resource problem, but there is a massive resource out there in the third sector, health and social care, the NHS and local government, and I am not sure that it is all coming together. We have also asked GPs whether they have all those support services around them, and even they have said that it is a bit hit or miss.

That is a question of leadership. Government is not about micromanagement, but surely we must ensure that we are getting the best from the resources that we have out there. Do you think that we are?

John Swinney: Mr Rowley is tempting me to go into an area that has been a significant source of frustration for me for some time. The Government could not be clearer about the need for joined-up working and person-centred activity at the local level. I have been banging on about that for years, and it is central to the Covid recovery strategy.

I would not describe the situation as casually as saying that it is “hit or miss”, as Mr Rowley does, but I do not think that it is perfect. The strength of third sector contributions is suitably, or possibly

even fully, taken into account in some parts of the country, but I do not think that it is in other parts of the country, and I do not think that it is all person centred. I think that there is still an increasing extent to which members of the public are expected to join up public services, whereas it should not be for them to do that; it should be for public services to be joined up and available to members of the public to access.

10:45

Those messages are absolutely central, and I am very confident that the message that Mr Rowley seeks to put forward is being put forward by ministers. I hear it being put forward by the health secretary and by the social justice secretary in her dialogue with local government. I certainly put it forward in my dialogue with both of them. Indeed, those two Cabinet colleagues and I used the opportunity of a discussion with more than 200 people who work in the leadership of health and social care activity around the country—the fact that 200 people had to be on the call tells its own story—to stress the importance of ensuring that all capacity, no matter whether it comes from the third sector, the private sector or the public sector, is woven together into a single proposition that is available for members of the public.

I think that that is strong in some parts of the country. In other parts of the country, there is still a distance to be travelled.

Alex Rowley: Okay. We know that we have a major problem coming our way—which is getting worse—in the cost of living crisis. At some point, will the free lateral flow testing cease? Will people have to pay for it?

John Swinney: No.

Alex Rowley: Okay. That is good.

John Swinney: For the absolute avoidance of doubt, lateral flow tests will remain free of charge.

Alex Rowley: Thank you.

John Mason: I asked you this question at committee some time ago, Deputy First Minister, and I am going to ask it again. The last time I looked, the number of people in hospital was 1,999. I look at the figures every day, and that figure concerns me quite a lot. We heard from the health secretary earlier that the hospitals are really toiling. Should we really be lifting any restrictions on Monday?

John Swinney: There are two numbers that I encourage Mr Mason to look at. The total number of people who are in hospital with Covid is important, but just as important is the number of new admissions week by week, by comparison. The latter number—the number of people being admitted to hospital week by week—is beginning to show a reduction. I was going to say that it is tailing off. I do not think that I could justify saying that, but it is certainly reducing on a weekly basis. That indicates to me that we appear to be getting over the peak of the challenge that we face from BA.2.

On that justification, I think that we are in an appropriate place to undertake the relaxations that will take place on Monday. However, I also note that the Government has taken the difficult decision, which I recognise is not universally popular, that one of the relaxations that was proposed for Monday will not be permitted. That is the relaxation of the legal obligation to wear face coverings in public spaces. We judged that, given where we are in this challenge, it is appropriate and proportionate to extend that measure for a further two-week period, and then to review it. By that time, we should have clearer evidence that we are over the peak of BA.2 and we will be able to more confidently take that step. I appreciate that that position is not universally supported, but I judge the decision that the Government has made to be the right one.

John Mason: I move on to testing, as I would like clarification on one or two points. Testing is going to carry on if somebody visits a care home and in certain other circumstances. As an example, I might want to visit my elderly aunt. In the past, I have tested before going to see her because I feel that she is vulnerable. It is not going to be possible for me to do so in the future, is it?

John Swinney: If you have any lateral flow testing kits available, you will be able to do so.

John Mason: If I keep them, yes, but I will not be able to get any new ones after the end of April.

John Swinney: That is correct.

John Mason: I read that two months' worth of testing capacity will be kept in case of another uptick. Presumably, however, the kits go out of date after a while and will have to be thrown out. How often will we—or the Government—have to keep replenishing them?

John Swinney: There will be an on-going element of testing as we go forward. It is not that we will just have all those testing kits in a locked warehouse. The supply will be replenished to avoid exactly the situation that Mr Mason—very fairly—puts to me, so that we utilise the resources that we have at our disposal.

John Mason: The isolation grants are also due to cease as part of the overall measures. Does that mean that we will go back to the other system whereby, if anyone has to isolate for Covid or any other reason, the health board has financial responsibility for getting them to do so?

John Swinney: We are looking carefully at the issues around self-isolation grant support. Fundamentally, we need to recognise the interaction between individuals' practical circumstances and the necessity of interrupting the circulation of the virus. The advice that will be available will encourage people to remain at home, in the same way that we would advise people with other conditions who might run the risk of spreading illness to other members of society.

We are looking carefully at the arrangements around self-isolation, because I recognise the challenge that Mr Mason raises. It might not be financially practical and possible for individuals to be able to self-isolate without loss of income. The points that Mr Rowley put to me about the cost of living crisis that people are facing is another dimension of it, and we are looking carefully at what other arrangements can be put in place.

I stress that the arrangements under the Public Health etc (Scotland) Act 2008 are designed for very limited outbreak purposes, and are not really suitable for the much wider proposition regarding the scenario that Mr Mason puts to me.

John Mason: Yes—that point came up when we looked at the legislation.

John Swinney: Yes.

John Mason: I move to my final area of questioning. Murdo Fraser touched on vaccinations and take-up levels. As usual, I have looked at some of the figures that we have been given. I see that among 30 to 39-year-olds, only 57.6 per cent of males have had a booster. That is quite a lot lower than the proportion in older age groups. I also looked at the figures for Glasgow, where I saw the lowest figure—66.1 per cent—for those who have had three vaccinations, including the booster. Are we making any progress on those numbers, or do we just accept that it is an on-going challenge?

John Swinney: We have to persist with the message about the importance of vaccination. As I said in my answers to Murdo Fraser, I am concerned by an attitude of mind that says that omicron is much softer than previous variants. That view is allowed to prevail precisely because of the robustness of vaccination. If we do not have robust vaccination, we will be exposed to much more serious illness.

That brings me back to Mr Mason's first question, about hospital admissions. If people are more seriously ill and spend more time in hospital, those numbers will not come down, and our hospitals will face a problem. I come back to the point that I have reiterated to the committee on a number of occasions: our national health service came closer to being overtopped during omicron than during any other part of the experience of Covid.

Brian Whittle: I want to follow up John Mason's comments about occupied beds. Cabinet secretary, you alluded to the fact that we are starting to see a switch from beds being occupied by Covid cases to beds being taken up by patients with other conditions. That issue was also mentioned during the previous agenda item. Are we getting to a point at which the other conditions that have been delayed are beginning to present? Is that the next crisis that the NHS will face? Will dealing with delayed presentations maintain the pressure on it?

John Swinney: I do not have the precise comparative numbers in front of me today, so I hope that Mr Whittle will forgive me for giving rough numbers based on my recollection. Three weeks ago, when the Government set out the strategic framework, the number of people in hospital with Covid was about 1,060—that is the figure that comes to mind. On Tuesday, that number was a few short of 2,000. It had virtually doubled in the space of three weeks. That high level of in-patients is why the Government has not followed through on all the steps that we intended to take on 21 March.

Obviously, there is a world of a difference between having about 1,000 patients in hospital with Covid and 2,000 patients. It leads to significant challenges relating to the treatment of patients with Covid, such as the need to isolate them from other patients, which undermines hospital capacity.

We really must see those numbers come down significantly. We are seeing signs of that happening now, but we need there to be further reductions to create the space for smoother access to hospital care for people with a variety of other conditions.

Brian Whittle: My concern is that, if we reduce the prevalence of Covid to the hoped-for levels, the pressure on the health service will simply move from treating Covid to treating other conditions whose presentation has been delayed. Is that a reasonable assumption to make?

John Swinney: Yes, that is a fair assumption. As Mr Whittle has said, the issue that most troubles leaders in the health service right now is that we have come out of an intense period of managing Covid, and it is likely to be followed by an intense period of managing non-Covid conditions.

Winter in the national health service is lasting an awful long time. In fact, winter feels like it is here all the time. Winter pressures tend to last between October to March. We are almost at the end of March and it does not look like the situation in

hospitals is improving to any extent whatsoever. That places a huge burden on members of staff, who are already very tired. Some of them will also have been ill, and they might still be trying to fully recover. As we all know, one of the effects of Covid is that people often experience fatigue over a long period. Health service staff are putting in very demanding shifts. If they are tired when they start them as a result of their having had Covid, which is highly likely, given where they are working, that is an additional burden for the health service to manage.

Professor Leitch: There are three predictable categories in which the pressure will, without question, continue. Those are: late presentations of new disease; existing presentations in which people are on waiting lists; and mental health. All those are worse post Covid because of Covid. You simply cannot treble intensive care capacity without that having an effect on what you can provide.

There is some positive news. We do not have any flu or any respiratory syncytial virus to talk of. Also, some of the elective care is done by different teams from the teams that I talked about in the previous agenda item and the people that the Deputy First Minister has just said are tired. Some of our surgical teams are very much ready to go and looking forward to getting back to treating people. However, about 15 per cent of our beds still have Covid patients in them. I know that we say this all the time, but the key is to get prevalence down. Then, you can get stuck into—forgive the tone—those three categories, because we must get them done.

11:00

As I have said previously in this committee, 40 per cent of people who end up with a cancer diagnosis do not have a cancer referral—they are referred for something else, and we discover that they have cancer during their pathway. If you are on an out-patient waiting list for pain or a lump, and you wait for a long time, your cancer diagnosis will be late. That is true in Scotland and in every major developed healthcare system in the world. That is why we need to get into those waiting times and late presentations.

Brian Whittle: We know that that pressure is coming, and I am sure that it is a global issue rather than something that affects Scotland in isolation. How do we prepare for the fact that, as I said, there are conditions that will continue to put pressure on the health service?

John Swinney: Essentially, we have to make considered judgments about the prioritisation of cases and resources. Although some treatments were paused during the pandemic, we maintained cancer treatment throughout it because it is important, and we also obviously maintained emergency care and interventions for individuals. We have to ensure that we prioritise, and that we maximise capacity.

The recovery plan proposals that the health secretary set out are about expanding capacity, recruiting more personnel to support us and ensuring that we have in place all the capacity that we need to enable us to support people. We then need to maintain our vigilance and our practical interventions to try to suppress the levels of Covid, which—as Professor Leitch just said—occupies a significant amount of capacity in the national health service.

Jim Fairlie: Mr Swinney, Alex Rowley asked whether testing will continue to be free for people, and you said yes. However, John Mason then asked whether people will have to pay for it after April. I am confused by your answers. Have I picked them up wrongly?

John Swinney: I did not say that to John Mason at all. We are currently advising people to test twice weekly. That advice will stop.

Jim Fairlie: In April?

John Swinney: Yes. However, if there is a requirement for people to test beyond April—there are some other requirements listed in the "Test and Protect Transition Plan"; the schematic indicates "Testing to Protect high risk" and "Testing for Clinical Care", for example—those tests will be free.

Jim Fairlie: That clarifies that point—thank you. However, to go back to John Mason's point, if someone wishes to continue to test, perhaps not regularly but for a particular reason, such as to visit a care home or an elderly relative, the test will not be available free of charge as it currently is.

John Swinney: There will not be an obligation on people to do so. That is what is different.

Professor Leitch: The judgment is made, and the change in definition is about what is high risk and what is not. Free testing will remain for high-risk settings. If someone is visiting a care home, we anticipate that they will still be provided with free lateral flow devices before they go. Mr Mason's quite legitimate question was about whether he will get a free LFD test to enable him to visit an elderly relative in a house, not in a care home. He will not. That is what the "Test and Protect Transition Plan" says.

Jim Fairlie: Would the Government prefer to be able to continue to supply free tests for people who want to continue testing?

John Swinney: There is a fine judgment to be made. There is a question—Government has to

wrestle with this at all times—regarding what constitutes proportionate action. If the prevalence of Covid was to reduce significantly in our society but we were still testing as if it was as virulent as it has been in recent weeks, I think that the Government would face some challenges as to the proportionality of our actions and requirements, and the use of public money, because there was not the community-wide prevalence that would justify a testing infrastructure of the type that we have had in place until now. That is why the risk-based assessment that is included in the transition plan is relevant for the judgments that we have made.

Jim Fairlie: Okay, but I am going to challenge you on that. We have just heard from the health secretary evidence that this week has been the hardest week in hospitals because of the pressures of Covid. It is now early March, and we are talking about testing being phased out by April. Are you confident that we can relax the testing regime by the end of April, given the current numbers?

John Swinney: We think that that is the case because, as I said in my previous answers, we believe that we have passed the peak of the BA.2 variant. We see that in a number of respects, including in cases and hospital admissions. Although the numbers in hospital are high, they are not being added to with the same vigour as was the case previously. Provided that that pattern continues, I would content, in the face of the evidence that Mr Fairlie puts to me—I know that this is a contested proposition and not everyone agrees with us—that the Government has taken prudent steps to deal with that.

If, for example, we had gone ahead and removed the legal obligation for face coverings on Monday, I think that Mr Fairlie would have had legitimate additional questions to put to me. However, we took the decision that we did. It caused some controversy—a number of people are kicking off about it—but, in my view, it was the responsible thing for us to do in order to provide a bit more protection and to try to get the situation under control.

Jim Fairlie: I am definitely one of the more cautious ones. I want to see a continuation of testing, as I want to ensure that we know where the virus is.

That takes me on to a technical question for Jason Leitch. On a number of occasions, Mr Swinney has talked about waste water testing. Will you explain that, please?

Professor Leitch: Yes. I will try to do so politely, because it is still morning.

John Swinney: There is not a polite way of describing it.

Professor Leitch: Fundamentally, when someone is positive with Covid, they shed virus in their bodily fluids, whatever those might be. We can find genetic material from Covid in the sewage around the country so, depending on where the sewage sites are and how small or big they are, we can tell in rough terms where Covid is. That gives us an early warning because people often shed the virus in their bodily fluids before they have symptoms.

As the Deputy First Minister is sitting beside me, I ask him whether he remembers the three sisters chicken outbreak.

John Swinney: Yes—it was the 2 Sisters factory.

Professor Leitch: I am sorry. I gave them an extra sister. [*Laughter*.]

John Swinney: You have exaggerated by 50 per cent.

Professor Leitch: At the 2 Sisters chicken factory, we knew that Covid was there because we found it in the sewage plant that served the plant, as there were so many people around. We can also do that in relatively localised areas of Glasgow, for example, so we can tell where Covid is. It gives us an early warning, and we will then be able to intervene with outbreak management and advice to the population. Crucially, the science has recently allowed us also to do genetic testing, so we can now tell which variant is in which place. That is just coming online.

We can think of waste water testing as an early warning score for Covid outbreaks in an area. If we were going to have an outbreak in a big call centre or in Arbroath or Elgin, we would get an early warning.

Jim Fairlie: Okay. I accept your science. However, with my cautious approach, I would much rather still see people testing on a regular basis.

Professor Leitch: What I have described does not replace testing. It adds to our ability to do surveillance. It certainly does not replace individual testing.

John Swinney: I return to the answer that I gave to a question from the convener, or perhaps from Mr Fraser: we are operating at two levels. On population-wide surveillance, a large measure of what we do has until now been informed significantly by polymerase chain reaction and lateral flow tests. We are now moving to a situation in which population-wide surveillance will be done through waste water testing and Office for National Statistics infection surveys. That recognises that the pandemic is changing. The strategic framework that the Government has set out indicates the developments that are taking

place in the pandemic and how we need to respond to them. It is appropriate that we adapt our stance as the nature and composition of the pandemic changes over time.

Jim Fairlie: Okay. I genuinely take your point, but I am asking these questions. We are also talking about people's perception of where we are with the virus. You spoke earlier—quite rightly—about people seeing omicron as being okay because it is milder, and you want to flip that view around. However, it seems to me that taking away testing adds another layer of complacency to people's thinking.

John Swinney: I unreservedly accept that there is a danger that people will become complacent about Covid. However, I want to assure the committee that the Government does not take that view. We have insisted on undertaking population-wide surveillance activity so that we are able to assess the general position on infection. Waste water sampling allows us to narrow that down to parts of the country and see where levels of infection are perhaps more intense. That can then inform outbreak management. We will still be active in that field. Some of the regulations that the committee will consider today are all about enabling us to undertake outbreak management. Without the regulations, we would not be able to do that as well as we should.

In addition, the risk-based approach to testing is part of the plan that the Government has issued.

Jim Fairlie: Okay—thank you. Do I have time to ask about outbreak management, convener?

The Convener: Yes.

Jim Fairlie: I will be quick. I know that I am taking up a lot of our time.

Skimming through the strategic framework update, I see that one of the paragraphs states:

"To inform the response to an outbreak of a potentially dangerous variant of COVID19, the Scottish Government with Public Health Scotland ... Local Government and other partners, are developing the COVID-19 Outbreak Management Plan, which will set out the process and methods for responding to future outbreaks. We aim to publish this in spring 2022."

How far away are you from publishing the plan?

John Swinney: It will be published shortly. Essentially, the thinking around the plan has been informed by two years of experience of dealing with various outbreaks of different shapes and sizes around the country. Professor Leitch mentioned the significant outbreak at the 2 Sisters plant, and we have had a number of other examples in industrial, education and community settings, and in localities. Local health protection teams have developed a lot of good intelligence on how to respond in given circumstances.

In relation to the 2 Sisters plant, I remember the very effective approach that was taken by the public health team in Tayside, which decided not to recommend a localised lockdown, but to recommend isolation for staff and their families. That was a supremely successful intervention that was well executed and communicated. Essentially, that population was insulated from the rest of the population and there was no community transmission. That has been possible at certain moments of the pandemic.

In future, that is a more likely intervention to be undertaken than has been the case in the past six to nine months, when there has been extensive community prevalence, meaning that such tactics have been less relevant. The plan will draw on the expertise that has been built up over the past two years.

Jim Fairlie: Thank you. We will come on to the legislative side of things.

The Convener: Brian Whittle has a question, after which we will move on to agenda item 3.

Brian Whittle: Thank you, convener. I appreciate the opportunity to ask this question. I want to go a little bit further with Jim Fairlie's line of questioning. The aspects that we should continue to monitor as we travel on this journey were alluded to earlier. In an earlier session with the Cabinet Secretary for Health and Social Care, Professor Leitch mentioned the extensive data in a paper in *The Lancet*, which includes global measurements. What should we continue to monitor locally so that we can put our data into a global perspective, perhaps using the World Health Organization's advice on data gathering?

11:15

John Swinney: There are different elements to that. We have to continue to monitor locally for two purposes. The first is to assess prevalence. Do we have the right positioning? The strategic framework sets out risk levels. Just now, we consider ourselves to be at a medium risk level. I hope that we will get to a low risk level fairly soon. Obviously, if we get to a high risk level, we will have to take other steps. That is about pandemic management in our society, for which we have absolute responsibility.

The second element is our contribution to the global understanding of where we are. Professor Leitch might want to add elements to what I say on that, but if we see the emergence of a new variant in our society, we have an absolute obligation to make sure that we alert every other jurisdiction. If a new variant of the virus develops in Scotland, it will be our global obligation to identify it and share the information with others.

There are two levels. First, how do we control the pandemic in Scotland? Do we have the right positioning? Are the strategic and testing frameworks appropriate for the times or do we need to shift what is in them? Secondly, are we able to contribute to the international understanding of what is happening with Covid? Without the tremendous research that was undertaken in southern Africa, we would not have got as much information—or information of such quality—about omicron. That helped us to respond as quickly as we did and to avert a very serious risk of undermining our national health service.

Professor Leitch: That covers surveillance very well. Those are the two things that we need to know. We need to know numbers and about variants, and we need that information at a global level. For example, there is almost no testing in Haiti so, if the variant comes from there, we will be completely in the dark. There is extensive genetic testing in South Africa so, if it comes from there, we will know. If it comes from here, we will know.

As I argued in the earlier session, we also need two other things. We need research on disease course so that we know how the disease is changing, who it is affecting, who is living and who is dying. We also need to know about treatment. This early in a new infection—it is two years since the disease arrived—we have to continue to follow people so that we know whether our drugs are working. That requires considerable resource and investment, and we need to follow patients over a long period. The work includes trials with universities, as well as Government support across the UK and the world, to allow us to get better at finding the disease and treating it.

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

Agenda item 3 is consideration of the motions on the made affirmative instruments that were considered in the previous agenda item and on two instruments on which we took evidence at our meeting on 24 February. Deputy First Minister, would you like to make any further remarks on the Scottish statutory instruments listed under agenda item 3?

John Swinney: I will make some comments on the contents of these sets of regulations.

The Coronavirus Act 2020 (Alteration of Expiry Date) (Scotland) Regulations 2022 extend the expiry date of temporary provisions in the UK Coronavirus Act 2020 by a further six months, thus ensuring that specific powers in the UK act will continue to be available to ministers until 24 September 2022.

The Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Amendment Regulations 2022 change the expiry date of the local authority direction regulations and will ensure that the powers given to local authorities in those regulations continue to be available to manage local outbreaks of coronavirus.

The Coronavirus (Scotland) Acts (Amendment of Expiry Dates) Regulations 2022 extend all the provisions in part 1 of each of the two Scottish coronavirus acts from 31 March 2022 to 30 September 2022, except for four provisions that will be expired by a further statutory instrument, the Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2022.

Finally, the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 5) Regulations 2022 remove from the principal regulations of the Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021 the provisions in relation to the Covid-19 vaccination certification scheme.

The Convener: Are members content for the motions on the agenda to be moved en bloc, with the set of the three extension regulations that relate to the UK and Scottish coronavirus acts taken together, followed by the remaining two instruments?

Members *indicated agreement.*

The Convener: I invite the Deputy First Minister to move the motions.

Motions moved,

That the COVID-19 Recovery Committee recommends that the Coronavirus Act 2020 (Alteration of Expiry Date) (Scotland) Regulations 2022 (SSI 2022/40) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Amendment Regulations 2022 [draft] be approved.

That the COVID-19 Recovery Committee recommends that the Coronavirus (Scotland) Acts (Amendment of Expiry Dates) Regulations 2022 [draft] be approved.—[*John Swinney*]

The Convener: Do members have any comments?

Murdo Fraser: Consistent with the view that we have taken on other occasions, I oppose the motions. We have been round the houses on this issue a number of times, so I will not tire the committee by going over all the arguments again.

The instruments seek to extend by another six months the emergency powers that were taken by the Scottish Government to deal with the coronavirus pandemic. We had some discussion earlier around the paper in last week's *Lancet*, which, as the first peer-reviewed global estimate of

excess deaths, observes no clear relationship between levels of excess mortality and different levels of restrictions. In addition to that, given that we know that the public adhere quite strictly to public health guidance, my view is that we should proceed to address Covid through public health guidance rather than through extending those extraordinary and emergency powers by another six months, as the instruments seek to do.

I recognise that some aspects of the instruments are beneficial, such as the provisions to allow nurses, rather than doctors, to administer vaccines. As ever, the classic challenge for an Opposition party is that we cannot amend the statutory instruments before us; we must either accept them as a whole or reject them as a whole. Given the extent of the emergency powers that they seek to extend, we must, in this case, reject them as a whole.

John Mason: As we have just heard in the evidence session, there are 1,999 people in hospital. We hope that things will get better, but as things could get worse and there could be more variants in the next few weeks, this is not the time to end those emergency powers.

Jim Fairlie: I whole-heartedly agree with Mr Mason.

Murdo Fraser has just said that, by and large, the people of this country follow the rules or guidance but I recall that, in the chamber earlier this week, Sandesh Gulhane opposed the wearing of masks, saying that most people do not wear them properly anyway. I do not see the consistency in the message. Right now, given the numbers that we have, it would be crazy to do anything other than keep the possibility of using restrictions if we need them.

Alex Rowley: John Mason has made the point that the virus is not over. I hope and pray that we do not have other variants that mean that we have to go backwards again, but there is no certainty in any of that. I think that, given where we are, given where we have been and given the level of Covid just now, the majority of people in Scotland believe that the restrictions are not unreasonable. In fact, somebody said to me the other day that everybody knows somebody with Covid, so I do not think it unreasonable for us to have some protections, such as face coverings.

In a BBC television interview last night, somebody said that if, after all the suffering that there has been in Scotland, the worst that we had to suffer was having to wear a mask for a few more weeks just to have those protections, such a proposal would be perfectly reasonable. This debate is more about playing party politics than anything else. It is trying to create division where we should be creating unity, so I will certainly support the motions today.

Brian Whittle: To be honest, I am disappointed with Mr Rowley's characterisation of the matter, because it is entirely not the case.

The general public do not know that the majority of the rules that they face are not law, but guidance. They have been following them. My point is that the speed with which, as has been demonstrated, we can bring emergency legislation to the Parliament means that there is no need to continue with the emergency legislation that is in force. If it is required, it can be brought swiftly to the Parliament.

I reiterate to Mr Rowley that my opposition to the motions has nothing to do with party politics. The fact is that the majority of the rules that we follow are guidance, not law.

John Swinney: The arguments have been well aired. The points that Mr Mason and Mr Rowley have made recognise that the pandemic is not over in any shape or form. As a consequence, we must have measures available to enable us to respond, should the situation deteriorate.

On the issue of local outbreak management, which Mr Fairlie raised with me, the Health Protection (Coronavirus, Restrictions) (Directions by Local Authorities) (Scotland) Amendment Regulations 2022 provide for the necessary interventions for effective outbreak management in trying to deal with local outbreaks that might create a wider difficulty.

The Government seeks this extension to enable us to have the capacity to respond should we need to. It is not because we will exercise the powers; it is to give us the capacity to do so, as members of the public will expect. I would therefore appreciate it if the committee would support the regulations that are in front of it.

The Convener: The question is, that motions S6M-03075, S6M-03169 and S6M-03349 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Brown, Siobhian (Ayr) (SNP)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Rowley, Alex (Mid Scotland and Fife) (Lab)

Against

Fraser, Murdo (Mid Scotland and Fife) (Con)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 4, Against 2, Abstentions 0.

Motions agreed to.

The Convener: We now move on to the second group of motions. I invite the Deputy First Minister to move motions S6M-03202 and S6M-03354.

Motions moved,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No. 3) Regulations 2022 (SSI 2022/53) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 5) Regulations 2022 (SSI 2022/74) be approved.—[*John Swinney*]

Motions agreed to.

The Convener: That concludes consideration of the motions. The committee will, in due course, publish a report to the Parliament, setting out its decision on the statutory instruments that were considered at the meeting.

That concludes our consideration of this agenda item and our time with the Deputy First Minister. I thank him and his supporting officials for attending, and I suspend the meeting to allow the witnesses to leave.

11:29

Meeting suspended.

11:30

On resuming—

The Convener: Item 4 is consideration of SSI 2022/64, on which we took evidence under item 2. Members should refer to paper 4 in our meeting pack, as well as the policy note that accompanies the regulations.

This is a negative instrument and the deadline for lodging a motion to annul is 19 April 2022. As outlined in the policy note, it expires some of the provisions in the Coronavirus (Scotland) Act 2020 and the Coronavirus (Scotland) (No 2) Act 2020.

When the Delegated Powers and Law Reform Committee considered the regulations on 1 March, it had no points to raise, and no motion to annul the regulations has been lodged to date. If no member wishes to make any comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

The Convener: The committee's next meeting will be on 24 March, when we will continue to take evidence on the Coronavirus (Recovery and Reform) (Scotland) Bill.

That concludes the public part of the meeting. We now move into private for consideration of our final item.

11:31

Meeting continued in private until 11:42.

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