OFFICIAL REPORT
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COVID-19 Recovery Committee

Thursday 2 December 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 2 December 2021

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COVID-19 RECOVERY COMMITTEE

13th Meeting 2021, 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:

Mike Brewer (Resolution Foundation)
Michael Clancy (Law Society of Scotland)
Professor Jason Leitch (Scottish Government)
Sandra MacLeod (Aberdeen City Health and Social Care Partnership)
Susan McKellar (Scottish Women's Convention)
Elizabeth Sadler (Scottish Government)
John Swinney (Deputy First Minister and Cabinet Secretary for Covid Recovery)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 2 December 2021

[The Convener opened the meeting at 09:00]

Coronavirus (Discretionary Compensation for Self-isolation) (Scotland) Bill: Stage 1

The Convener (Siobhian Brown): Good morning, and welcome to the 13th meeting in 2021 of the COVID-19 Recovery Committee. This morning, we will take evidence on the Coronavirus (Discretionary Compensation for Self-isolation) (Scotland) Bill at stage 1.

I welcome Sandra MacLeod, chief officer of the Aberdeen city health and social care partnership; Michael Clancy, director of law reform at the Law Society of Scotland; Mike Brewer, deputy chief executive of the Resolution Foundation; and Susan McKellar, operations manager at the Scottish Women's Convention. Thank you for giving us your time this morning.

This will be the first of the committee's evidence sessions on the bill before we hear from the Deputy First Minister on 16 December. Each member will have approximately 12 minutes to speak to the witnesses and ask their questions. We should be okay for time, but I apologise in advance if I have to interrupt members or witnesses in the interests of brevity.

I will ask the first questions. What are your views on the rationale for the bill? Is the bill as proposed the most appropriate route for achieving its objectives?

Sandra MacLeod (Aberdeen City Health and Social Care Partnership): Good morning. The bill's support for people on low incomes in helping them to remain in self-isolation is a positive move. In addition, from a national health service perspective, not returning to the previous date is also a positive move, given the impact—[*Inaudible*.]—that that would have.

The Convener: Sorry—I think that your sound has cut out. Do you have anything else to add?

Sandra MacLeod: No.

The Convener: Thank you.

Michael Clancy (Law Society of Scotland): Good morning. I will not comment on the appropriateness of the policy; I can leave that for others to do.

On whether the bill is the most appropriate measure, the policy memorandum makes it clear that alternatives were considered. One was to allow the mandatory compensation provisions in the Public Health etc (Scotland) Act 2008 to resume when schedule 21 to the Coronavirus Act 2020 expires. Another was to issue regulations under sections 56 and 58 of the 2008 act, but there were doubts about whether those regulations would be flexible or broad enough. It would also have been possible for the Government to use powers under section 90 of the Coronavirus Act 2020 to extend the modification of the 2008 act, but that extension would, initially, have been only to 25 September 2022, and such modifications would be subject to six-month extensions thereafter.

Therefore, I can see perfectly clearly why the Scottish Government alighted on the solution of producing the bill that is before the committee today. I have not consulted any of my colleagues on this, so I hope that I am not talking out of turn, but it seems to me that the bill is the most appropriate way to go. It is clearer, it allows the Government to achieve its policy objective and it ensures that we get the opportunity to give evidence to the committee, as we are doing today.

Mike Brewer (Resolution Foundation): The bill is an odd one because, basically, its purpose is to stop the Scottish Government paying out large amounts of money to everyone who has to self-isolate, with an estimated cost of £300 million a year. It focuses attention on the support that exists for people who need to self-isolate through the self-isolation support grant. It is vital that that grant continues while the coronavirus crisis continues and there is a pressing need for people to be able to self-isolate.

Susan McKellar (Scottish Women's Convention): We support the bill. Anything that will help families on a low income to maintain a level of income while they are having to self-isolate is of benefit. Given the uncertainty around coronavirus at the moment with new strains coming out, it is more important than ever that we keep the flexibility to be able to provide the self-isolation support grant for those on the lowest incomes.

The Convener: We move to questions from Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. I would like to ask about two different areas. My first question is for Michael Clancy. In your submission on behalf of the Law Society, you make a process point about the Scottish Government's power to make regulations and the requirement that it should publish a statement of reasons along with such regulations. You say:

"it should be made clear that the statement of reasons should also explain why it is necessary to make the regulations urgently before they were approved by the Parliament."

Could you expand on that and explain the background to your thinking on that point?

Michael Clancy: The provisions in section 4 of the bill on the making of regulations include the provision that

"If the Scottish Ministers consider that regulations ... need to be made urgently ... subsections (2) and (3) do not apply, and ... the regulations (the "emergency regulations") ... must be laid before the Scottish Parliament, and ... cease to have effect on the expiry of the period of 28 days beginning with the date on which the regulations were made".

Therefore, if emergency regulations are made, the Scottish ministers must at the same time lay before Parliament a statement of reasons for making the regulations. The point is that there is no definition of "emergency". The only reason that is given in section 4(4) is that the Scottish ministers consider that regulations

"need to be made urgently".

Why they think that regulations need to be made urgently is the question to which we are seeking the answer.

That is why we have suggested that the statement of reasons should also explain why ministers require

"to make the regulations urgently before they were approved by the Parliament."

There could be many reasons for that—for example, there could be a significant spike in coronavirus cases across the country or there could be issues in relation to finance. It is not for me to speculate as to what the Scottish ministers' reasons might be in the future.

However, we think it appropriate for ministers to be transparent about the reasons for urgency, and for those reasons to be made clear to Parliament, so that, in contemplating the regulations after they have been made—it is important to remember that Parliament will do that after the regulations have been made—it can assess whether it was appropriate for ministers to take the route in section 4(4).

I hope that that answers your question, Mr Fraser.

Murdo Fraser: That is helpful. We can take up the issue with the Scottish Government representatives when we see them.

I have a question on a different issue, which I will address to Susan McKellar from the Scottish Women's Convention. I was concerned to read in your consultation response that none of the women whom you consulted had been successful in accessing the self-isolation support grant or local self-isolation assistance service, despite them all having had to self-isolate. I do not know how many women you spoke to in that respect, so it would be helpful if you would clarify. It is clearly a point of concern, because the whole purpose of putting in place the grant scheme for self-isolation was to support those who are in that situation and need additional financial assistance.

Will you give us a bit more background, and explain why people were not able to access the grant? Did they find that it was too difficult to apply, did they apply and get turned down, or were there other reasons?

Susan McKellar: We wanted to put in a consultation response with regard to the self-isolation support grant, so we put out, through our network, an online survey, which reached more than 4,000 women. I think that more than 100 women replied to the survey. We also went out to our networks and asked women whom we knew had self-isolated whether they had received the grant. Some of them did not even know that it existed and that they were able to claim, and others said that they did not know how it would affect their current benefits. Some people were on universal credit and thought that, if they claimed the grant, the money would get taken off their universal credit in the future.

There was not much information coming out from the advisers. One lady phoned to find out whether she was entitled to claim, and when she was asked whether she was on benefits, she said no. She was in a low-income bracket, but she never claimed benefits because she always worked. As she did not claim the benefits, she was told that she was not entitled to the grant, although she probably would have been entitled because she was not even on the real minimum wage. However, that put her off applying for the grant.

In other cases, people thought that it would be too much hassle to go through the process to get the money, or that, by the time they got the money, they would be back at work anyway, so they did not bother. That was another reason behind it.

Access also depended on which health board was putting out the information. One woman said that she got an SMS text message saying that, if she wanted to apply for the grant, she could do so by replying to the SMS. Seven weeks later, she had not received anything back.

A lot of different things are contributing to preventing women from accessing the funds. I think that some women did not want to claim benefits due to the stigma and discrimination that are attached to doing so. Those are just some of our findings after speaking to the women.

Murdo Fraser: That is really helpful.

To follow up on that point, did you get a response from the women whom you consulted as to whether they thought that there was enough publicity around the scheme? Were they aware of it? If so, how did they hear about it?

Susan McKellar: We heard from women that there was not enough publicity about the scheme. There should have been information in health centres and other places that they were able to access at the time. They should have been advised about the scheme at the first point of contact. The situation has been getting better, but when the grant was introduced earlier in the pandemic, not much information came out about it.

As you can see from the statistics, since the furlough scheme stopped, uptake has increased. People have had to look for money from elsewhere because they do not have any other income when they have to self-isolate.

Women also said that the closure of libraries and other places is making it more difficult for them to access information. In addition, technology poverty means that people do not have online access at home. Therefore, the information has to be more accessible for women; it needs to be available to them at places where they are able to go at the moment. The women felt that there was not enough support to access the services and have someone talk them through the process.

Murdo Fraser: Does Sandra MacLeod or Mike Brewer want to add anything? Sandra MacLeod is nodding.

09:15

Sandra MacLeod: Really valid points have been made. To pick that up, I will share local practice from Aberdeen. The poverty agenda is significant in relation to health, so it is important that people can access all the support. From the area, we have received 3,234 applications for the grant, but the reward rate has been only 53 per cent. The approach was initially restrictive, but changes have definitely helped that to move forward.

A dedicated web page and online application form have been created. When staff phone to tell people that they must go into isolation, they promote the scheme and offer help to fill in the application—if that is required, someone will phone back. We also have our crisis support line for people, which might help with online challenges.

I acknowledge what Susan McKellar said. However, there is evidence, and people are promoting the opportunity to help under the poverty agenda.

John Mason (Glasgow Shettleston) (SNP): Mr Brewer said that the bill is unusual in that it will involve saving rather than spending money. I know that, if we left the 2008 act in place, the total cost could be £380 million, but what would an individual be entitled to instead of £500? Does Mr Brewer know?

Mike Brewer: The answer is that the figure is not known. The estimates that were given by the Scottish Government or by the Scottish Parliament information centre—I forget which it was—recognised that the cost might be very high, at £300 million, because the Government might be obliged to compensate high earners for their full earnings loss. That is one reason why the cost of not passing the bill would be very high. If everybody had to be fully compensated for their earnings loss, regardless of their earnings level, the cost to the Scottish Government would be very large.

John Mason: Does that happen if somebody gets Ebola? Has the 2008 act ever been used in that way?

Mike Brewer: I am afraid that I do not know—sorry.

John Mason: Can any other witnesses help me? It does not look as if they can. I will ask the Government the question when it appears before the committee. I think that the Scientific Advisory Group for Emergencies said, as a comment, that we need to provide full pay and comprehensive support, but that would be expensive.

We are not looking at the payment level, but some submissions covered the figure of £500. I am not sure who to put this question to—perhaps it is for Susan McKellar. Is £500 appropriate? Has the system worked? You said that a lot of people have not received the payment. Should the amount be higher? Should the payment be organised differently?

Susan McKellar: The £500 is beneficial to anybody who is getting no income. Quite a lot of the women we spoke to were on low incomes—for example, they were in minimum-wage jobs in the hospitality sector that were precarious and had zero-hours contracts. For them, any money would help.

The women who did not claim said that they lost money in real-terms benefits, because they had more electricity and food costs. They had to do their shopping online from shops that delivered, which are more expensive than shops that do not deliver—supermarkets such as Aldi and Lidl are a lot cheaper than Asda, Morrisons and Sainsbury's, but those are the only ones that do deliveries. One woman said that she used quite a lot of her savings in isolation, because she did not think that she was entitled to claim the benefits.

We would say that £500 is a fair estimate, but it should be in line with real life. Poverty is the major factor, so we need to ensure that the amount meets the real living wage criteria, which might be more than £500. It would need to take account of each aspect—what that person was earning and missing out on in real terms, including their electricity and food.

John Mason: I will stick with you. I think that the figures show that only one in eight workers are entitled to the payment and you have made the point that some people are not getting it. What about a single mother who is a bit further up the scale? Perhaps she is just managing to cover her mortgage, food, electricity and all the rest of it, but she will not get anything for self-isolating. Is there a problem there?

Susan McKellar: We think that there is a problem. Those are the people who can get tipped into that poverty bucket, as we would say. Ten days is a long time not to have any income, and it was 14 days before. If someone is not entitled to the grant and their employer pays them only statutory sick pay, they will lose a big chunk of their money and they probably do not have any savings to dip into. It will set them back and they will always be trying to get back on their feet and on to an even keel.

With the cost of electricity going up, fuel poverty is a major issue at the moment, as is food poverty and insecurity. More people are trying to access food banks than ever before and most of them are working. They would come into the same category. Eligibility should be looked at on that basis. What would be the real cost to someone of spending that time in isolation and would it put their income below the real living wage? If so, they should be entitled to the grant.

John Mason: My final question is for Sandra MacLeod, but anybody else can come in, too. When people are asked whether they self-isolate when they are meant to, 94 per cent say that they do, but figures show that in practice only 74 per cent do so. People's claims are somewhat out of line with what they do. What is your feeling about self-isolation? Is it working? Are people doing it?

Sandra MacLeod: Our understanding is that it is one of the key contributors to breaking the chain of spread of the disease, so it is helpful. The situation is progressing, but I suppose there will always be people who choose not to follow the guidance and do not self-isolate. As Susan McKellar has rightly highlighted—and the bill is trying to achieve this—anything that we can do to encourage and support people to self-isolate is a positive step.

John Mason: Is there anything that we could do apart from paying the money?

Sandra MacLeod: I am not sure. We are encouraging people to do it. We can give them acknowledgement. We have contract tracers and provide a high level of support, including volunteer assistance. All that is in place, but it sometimes comes down to personal choice and whether people are willing to expose other people to the risk.

Alex Rowley (Mid Scotland and Fife) (Lab): I want to pick up on something that Sandra MacLeod said. I was interested to hear what Aberdeen city health and social care partnership is doing to promote the grant. It would be good if you could send that information to the committee. Does any member of the panel think that there is a general issue about promotion? Should the Government and people on the ground do more to promote the fact that people can get support if they are struggling?

Susan McKellar: We can always do more to promote these kinds of grants and initiatives. The problem is that we are bombarded with so many different messages and they change a lot, so people are not sure what the current guidelines are and what processes they should go through. The television adverts promoting self-isolation and staying in are great, but they do not say that people are entitled to support. They do not tell people to ring a national phone number to check whether they are eligible for a self-isolation support grant. More has to be done on that.

More than 700,000 people have had Covid— [*Interruption*.]

The Convener: Susan McKellar's screen has frozen. Can we bring in Michael Clancy?

Michael Clancy: Two thoughts crossed my mind in relation to this discussion, but Susan is back live now so perhaps she wants to conclude her point.

The Convener: She is not back yet. We cannot see her on our screens.

Michael Clancy: Okay, thank you. Two thoughts crossed my mind. First, under section 56 of the Public Health etc (Scotland) Act 2008, there has to be a notification in writing that the person is required to quarantine or self-isolate, as we call it. That notification in writing might be where information about the grant is made available directly to the individuals concerned who would be eligible to get a discretionary payment under the act. That might be a way of getting the Scottish Government to explore getting the information directly to those who might be eligible to claim the self-isolation support grant.

Secondly, I turn to Mr Mason's point about 90 per cent of people saying that they will comply but only 70 per cent doing so. If a dispute arises about

a person's entitlement under section 56 of the 2008 act—in other words, whether they have self-isolated—or the amount of compensation, the act contains a dispute mechanism that allows for arbitration. If that does not result in agreement, it will then go to the sheriff.

Applying those sorts of solutions to questions about entitlement to the grant might take another leap of faith and might require further tweaks to the legislation, but it gives us an idea of resolutions to the issue of getting notification about the information, the question of who is isolating and whether they are actually doing it, and how one can resolve a dispute that might arise about entitlement to a grant rather than compensation under the act.

I hope that that is helpful.

The Convener: Susan McKellar is back and she would like to come back in.

Susan McKellar: I am sorry about that; I lost my signal.

I was saying that it would be helpful to do more with adverts and stuff like that to show people, especially those on a low income, that there is support out there.

I was listening to what Michael Clancy said about the grant and I think that there has to be discretion there. We had one woman who said that her contract for a new job was due to start the day after she was told to isolate, so she was not entitled to the grant or any statutory sick pay and that left her in a precarious position for 10 days. We have to look at discretion in the bill. We have moved the issue forward on some of the criteria for the grant that Sandra MacLeod talked about earlier, but we need to look at certain conditions in an intersectional way to see what kind of things can happen and how we can make sure that as many people as possible can get the grant.

More than 700,000 people have had Covid, but there was only a 6 per cent uptake, and we know that poverty is a lot higher than that.

We know that people are not claiming, so we need to do more to ensure that they are aware that they can access it. People are not getting reasons why they are being rejected; sometimes, they are just told, "Your claim is unsuccessful". We need to be more transparent about why claims are being rejected, and we need to keep information and data about that in order to see whether certain groups of people are missing out and for what reasons.

09:30

Alex Rowley: Thank you. Those points are important in looking at the wider spread.

I have a quick question for Michael Clancy about the relevance of the 2008 act. There is consensus that it would not be suitable for the current Covid pandemic. Is the act too widely drawn? Do we need to revisit it at some point?

Michael Clancy: We have recommended that the whole vista of emergency legislation needs some revision in relation to whatever emergencies there might be. Prior to the pandemic, the options that would have been at the hand of Governments to deal with things would have been the Public Health etc (Scotland) Act 2008 or the Civil Contingencies Act 2004. We have not seen or heard of the 2004 act since it was enacted and applied, I think, in relation to some agricultural emergencies in the early 2000s.

There is a need to look at why we got into the position whereby, in 2020, the United Kingdom Coronavirus Act 2020 had to be enacted at such speed, with only four days of parliamentary consideration in Westminster, and why it was necessary for the Coronavirus (Scotland) Act 2020—the Scottish Parliament's first coronavirus act—to be taken under the emergency procedure. We can understand why its second coronavirus act—the Coronavirus (Scotland) (No 2) Act 2020—could be taken at a little bit more leisure. Nevertheless, the fact that we had to make all that law indicates that our previous law for dealing with emergencies might not have been fit for purpose or up to dealing with such problems.

After the current emergency is truly over and things have settled down sufficiently—I cannot begin to predict when that will be—we should all get our heads together, look closely at our emergency legislation and apply it. Clearly, the coronavirus legislation applies only to coronavirus. If some other viral agent or form of emergency were to be visited on us, we could not just apply coronavirus legislation to that circumstance, so what would we do? We need to consider a law for emergencies and make sure that it is fit for purpose and flexible enough to meet every contingency.

The Convener: I would like to bring in Sandra MacLeod.

Sandra MacLeod: My response has been covered by the two previous witnesses.

The Convener: Okay—thank you. I will go to Jim Fairlie.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I want to come back to Michael Clancy on the point that he just made. The Civil Contingencies Act 2004 was brought in following the foot and mouth outbreak in 2001 to prevent people's access to the countryside and farms. Is that a UK act, and does the Scottish Government

have any access to it? Is it reserved or can the Scottish Government use it?

Michael Clancy: Let me just call it up on my computer so that I can answer your question. It was enacted in 2004 and covers all kinds of civil contingencies, not simply foot and mouth. It was not directed at that specific emergency but at all kinds of emergencies.

The meaning of "emergency" under the act is

"an event or situation which threatens serious damage to human welfare in a place in the United Kingdom, ... an event or situation which threatens serious damage to the environment of a place in the United Kingdom, or ... war, or terrorism, which threatens serious damage to the security of the United Kingdom."

For the purposes of explaining that, it goes on to describe, for example,

"loss of human life ... human illness or injury"

and

"disruption of services relating to health"

as other causes or features of an emergency.

One could argue that the act could apply to the coronavirus situation. However, in evidence either to the Constitution Committee of the House of Lords or to the Public Administration and Constitutional Affairs Committee of the House of Commons, Michael Gove explained that the act had really only been brought into effect in contemplation of something larger than a virus and was more focused on war or some other such contingency. The coronavirus legislation has been brought in specifically to deal with Covid-19. The 2004 act has a far broader conspectus and is more applicable to other forms of disruption to our national life.

You asked whether the act is amendable by the Scottish Parliament. It is UK legislation and I think therefore that the answer is that it is not amendable. I have not checked schedule 5 to the Scotland Act 1998, but I think that civil contingencies are a reserved matter.

Jim Fairlie: You have raised something that I had not thought about. I had never heard of the Civil Contingencies Act 2004. I assumed that the act was about foot and mouth when you said that it was from the early 2000s.

The 2004 act is there, and we currently have the Coronavirus Act 2020. I go back to what you said about the need to look at having some sort of public emergency act after this is all done and dusted. Coronavirus has affected not only people's health. Should we have looked at a broader picture and used the 2004 act? The pandemic has affected business, freedoms, poverty and every aspect of society. Would it not have made more sense to use the 2004 act, which relates to civil contingencies, rather than creating an act that relates to health?

Michael Clancy: It is possible to debate which piece of legislation should be deployed for every circumstance and challenge that the country faces. It is likely that the 2004 act was looked at and discounted as not giving the UK Government and the devolved Administrations adequate powers to deal in very quick order with what was recognised as a global threat.

It was probably the right decision to go for a comprehensive piece of stand-alone legislation that dealt with the problems of the coronavirus. There was a four-nations action plan to deal with coronavirus in place at that time and the four nations agreed on coronavirus legislation as being the first building block of that. The devolved Administrations in Scotland and Wales created more legislation and subordinate legislation, which grew exponentially to cover all aspects of restrictions on movement and other issues too. It is fair to say that that was the right thing to do and that the 2004 act was probably thought about and discounted because it was not as broad-based and did not provide adequate powers to the Governments operating throughout the UK.

Jim Fairlie: I apologise for being an absolute pedant here, but if we had gone down the route of using the 2004 act, would it not have been the same principle that those powers would have been devolved for the period of time to allow the devolved Administrations to use them?

Michael Clancy: This is taking us off the topic of the day, but the Civil Contingencies Act 2004 was created with a different perspective on the challenge that might be faced. Parts of the act are usable—there is a way in which the act divides up the issues of urgency, consultation, enforcement and so on—and the use of emergency powers can be determined by a senior minister of the Crown. However, essentially, the Parliament would have to rewrite the act to take account of coronavirus, and if you were to try to modify the act to make it clear which authorities were being empowered to do what and what powers were being given, we would end up with the coronavirus legislation.

It was probably the right decision to go with specific coronavirus legislation and to deal with it in the way in which it was dealt with originally in the Coronavirus Act 2020, which was on a four-nations basis, but allowing the devolved Administrations to make law in the devolved sphere—and in Scotland, allowing the Scottish Government and the Scottish Parliament, to make law that was specific to Scotland, which dealt with amendments to Scottish law in the devolved sphere. We can cite examples of that in relation to movement in and around Scotland, movement out

of Scotland and questions about the way in which the courts operated and other things.

In one respect, we would have ended up in the same place, but the right answer was chosen to enact legislation specific to the threat of coronavirus.

The Convener: Mr Fairlie, does your next question relate to the self-isolation bill?

Jim Fairlie: Yes. My question is for Susan McKellar. You sent a questionnaire out to 4,000 people but got only 100 responses. I am not disputing the fact that we have to get our messaging better, but did you get 100 respondents who did not get the grant, although 500 did? How would you know how many people are not getting it? In Aberdeen, there were 3,234 respondents and a 54 per cent success rate. That is not high enough—I accept that—but why was your response rate so low?

Susan McKellar: I think that it was so low because everyone has got so much else going on at the moment. It is a busy period, especially for women who have had the joys of having had to home school and make sure that they were caring for other family members—those responsibilities predominantly land on women. The ones who responded to us were the most upset about not getting the grant because of the situation that it put them in. Other women were doing other things and were not even aware that it was a grant that could be claimed.

We think that there was a low response because we just send the survey out and take in what we can. We went out to our networks and asked women from different organisations what information they were getting back. Although 100 women responded to the survey, many did not, probably because of everything else that has been going on.

09:45

Quite a lot of our women members are teachers or parents, and some are older adults who do not have the technology to enable them to answer our surveys. That is a huge issue. The Scottish Women's Convention is trying everything that it can to reach as many women as possible, but some of the women in the Highlands and Islands do not have broadband, so we cannot get their views as regularly as we might otherwise do.

At the time of the survey, we did not have the support to enable us to phone people in order to get more respondents to give us that information. The responses that we got were from women who had experienced a negative effect and wanted us to be aware so that we could pass that information on to the Scottish Government and health boards. The respondents were from different health board areas, in which there were different outcomes. One woman was in West Dunbartonshire and another was in Glasgow, and they were dealt with by their health boards in totally different ways.

That just goes to show that there is a lack of parity, depending on who is dealing with the application. It sounds as if Aberdeen is getting it right and, from what we hear, Glasgow is doing quite well in getting the message out and informing people that there is a grant that they can get. However, other health and social care partnerships are not doing so well. That might be to do with the way that the NHS is running in those areas, and whether it is at capacity because of Covid.

Many of the women who are part of the Scottish Women's Convention are aware of that. They know that the NHS is to be protected, and some of them did not even want to apply for the grant because they knew that their application would take vital time away from other things in the NHS. That was another reason that we were given.

That is some background information on the survey responses.

Brian Whittle (South Scotland) (Con): Good morning. I will be reasonably brief, because a lot of the points that I wanted to cover have already been discussed.

The self-isolation support grant is there to encourage people to self-isolate, and to ensure that they are not put in a position where they have to make a decision on whether they self-isolate or are able to pay their bills. With that in mind, I want to raise a couple of points with Susan McKellar.

You talked about the impact on those who are on zero-hours contracts or in part-time work, who would perhaps feel the inability to work most keenly. They have an issue with having to prove loss of income, given their particular circumstances. Does that cause a difficulty for them in accessing the grant? At the end of the day, it is about ease of access to the grant.

You also mentioned those who do not fall within the criteria for the grant, but whose income versus expenditure may be finely balanced, as it is for many of us, and whose inability to work would seriously impact their ability to pay their bills. Is the scope of the grant wide enough?

Susan McKellar: We do not think that it is, with regard to what people are losing money-wise in real terms. Women on zero-hours contracts said to us that, because their work is precarious, even if they were able to isolate for 10 days and did not get work during that time because they could not do it, they would then be affected in terms of getting shifts in future. Some of those employers

are very unscrupulous and do not adhere to employment law in the way that they should, and the workers are not protected.

That issue came up in relation to unions. We spoke to women about being part of a union, especially if they are on a zero-hours contract. The issue was that that would cost them money, even though the cost is quite low. In addition, they do not want to rock the boat because that might prevent them from getting shifts in the future, which would have a serious impact.

Some of the women who had been told to self-isolate would do so, but they were pressured from their employer to hurry up and get back to work because the business was short staffed. That has a psychological impact on the person, who thinks, "I need to try to get back to work as soon as I can." If someone is not entitled to a grant, and they are not getting that money, it puts pressure on them to break the isolation rule. We need to look at that as well.

We need to look at income when it comes to zero-hours contracts. Some weeks, people could get 32 hours; other weeks, they could get eight. We need to look at how, overall, someone's income generally runs, as the Government does for tax credits; people are paid for a certain income and, if that goes up, the payment reduces—that kind of idea. We need to look at that especially for women who are on that breadline; if isolating is going to cause them not to achieve, in real terms, the living minimum income that they need, they should be entitled to get that grant. There should be something in there to say that they are able to claim for that and to prove their claim.

Brian Whittle: Thank you. I have a final quick question, probably to Sandra MacLeod, about the legislation's impact on the health boards. How would it impact on your health board?

Sandra MacLeod: Previously—I have checked—as has been said, there was not a huge uptake for payments under the 2008 act. The grants are managed by local authorities. People are informed through contact tracing. When people are contacted to say that they are required to isolate, the contact tracers ask whether they need assistance, advise them of the grants and link them to the local authority.

The impact on the health board, at this stage, would therefore not be significant—in a positive way. If the current arrangements were not in place, the workload and the distraction of processing all those claims and payments would have had quite a significant effect on the health board. The situation has, in a way, been positive and has allowed us to work with key partners across the systems. It has allowed local authority and health board colleagues to link with the third sector in a community planning approach.

To summarise, there is minimal impact on the health board, which is what was intended, and which has a positive impact on the health board's ability to deliver its services.

The Convener: Since no member has further questions, I thank the witnesses for their evidence and for giving us their time this morning. If witnesses would like to raise any further evidence with the committee, they can do so in writing; the clerks will be happy to liaise with them about how to do that.

I suspend the meeting to allow a changeover of witnesses.

09:52

Meeting suspended.

10:28

On resuming—

Ministerial Statements and Subordinate Legislation

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 7) Regulations 2021 (SSI 2021/425)

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 4) Regulations 2021 [Draft]

The Convener: Under agenda item 2, the committee will take evidence from the Scottish Government on the latest ministerial statements on Covid-19 and on subordinate legislation.

I will start by saying a few words about the draft Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 4) Regulations 2021. Last week, George Adam, the Minister for Parliamentary Business, asked to speak to me about the changes to the Covid vaccination certification scheme that the First Minister outlined on 23 November. At our meeting, George Adam explained that the Government is mindful of the concern that this committee and the Delegated Powers and Law Reform Committee have expressed about the use of the made affirmative procedure and he suggested an approach whereby an expedited affirmative procedure might be used on this occasion.

Members will have seen the correspondence from the Minister for Parliamentary Business explaining the Government's position. On this occasion, I was minded to accept that suggestion. That meant that the regulations were formally laid on Monday and were considered by the DPLR Committee on Tuesday.

Following its consideration of the regulations, the DPLR Committee has written to this committee. Members have a copy of that correspondence. Following our consideration of the regulations this morning, the regulations will be taken at decision time later today in the chamber.

Although I was minded on this occasion to agree to the Scottish Government's proposed expedited timetable for scrutiny, that should not be viewed as setting a precedent for future scrutiny. That is something that we can keep under review.

10:30

I welcome to the meeting our witnesses from the Scottish Government: John Swinney, the Deputy First Minister and Cabinet Secretary for COVID Recovery; Professor Jason Leitch, the national clinical director; and Elizabeth Sadler, the deputy director of the Covid ready society. Thank you for your attendance this morning.

Deputy First Minister, would you like to make any remarks before we move to questions?

The Deputy First Minister and Cabinet Secretary for Covid Recovery (John Swinney): Yes—thank you, convener. I am grateful to the committee for the opportunity to discuss a number of matters, including updates to Parliament this week and last week on Covid-19 and the incidents to which the convener has just referred.

As set out by the First Minister on Tuesday, although case numbers in Scotland have continued to fall, the emergence of the omicron variant is deeply worrying, and it requires a proportionate and precautionary response. There are now confirmed cases of omicron in Scotland and Public Health Scotland is working hard to identify any and all cases as quickly as possible.

There are indications that omicron might be more transmissible than the delta variant, which is currently dominant in Scotland. However, at present, there is no evidence to indicate that the disease that is caused by omicron is more severe than that caused by other variants. Our understanding of the new variant is developing, and we will know more—especially about the protection that is provided by vaccines—in the days and weeks ahead, thanks to the dedication of scientists across the world.

Although I very much hope that our level of concern will reduce in coming weeks, our precautionary approach is the right one for now. As the First Minister set out on Tuesday, at this stage, we are not introducing additional health protection measures beyond some necessary travel restrictions. Instead, we are asking everyone to renew their focus on following existing protections. We need people to wear face coverings where required, maintain good hygiene, work from home wherever possible, ventilate indoor spaces and test themselves regularly. Those protections are especially important as cold weather and the possibility of festive gatherings mean that we might be spending more time inside with other people.

This week, the Joint Committee on Vaccination and Immunisation updated its advice, such that 1 million more people are now eligible for booster vaccines. That is good news, as we know that vaccines are effective and save lives. Indeed, according to a study published last week by the World Health Organization, there might be more than 27,000 people in Scotland who are alive today only because of the vaccines.

With more than 88 per cent of the adult population having had two doses of the vaccine and more than 93 per cent having had one dose, Scottish ministers now consider it proportionate to amend the certification scheme to include negative test results. The change will make it possible for people who cannot be vaccinated, who are not yet fully protected, or who have received a vaccine that is not recognised by the Medicines and Healthcare products Regulatory Agency, to be able to attend venues that are covered by the scheme.

The Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 4) Regulations 2021 make the necessary amendments to the Covid-19 certification scheme. With effect from 5 am on Monday 6 December, the scheme will allow people to show a record of a negative test for coronavirus that was taken in the 24 hours prior to attending a venue as an alternative to proof of vaccination.

Certification continues to play a role in helping us to increase vaccine uptake, reduce the risk of coronavirus transmission, alleviate pressure on our health and care services, and allow higher-risk settings to continue to operate. It is an alternative to more restrictive measures, such as capacity limits, early closing times or closure.

I am very happy to answer questions from the committee.

The Convener: Thank you, Deputy First Minister. I remind members and witnesses that we are restricted for time and each member has around eight minutes for questions.

I will start with the first question. Deputy First Minister, the committee agreed to the expedited timetable because the Scottish Government's view is that the regulations require to come into force on 6 December. For the record, could you please explain why the Government considers that 6 December, and not another date, is when the regulations should come into force?

John Swinney: Essentially, we want the regulations to be in place to facilitate an increased level of protection and assurance in the run-up to the festive period. From 6 December onwards, people will be engaged in activities that are habitually associated with Christmas, including retail and hospitality opportunities. Putting in place the regulations at a moment when we are preparing for such events is the pragmatic approach that the Government wants to take to maximise protection and to maximise the involvement of members of the public in the assurance that we are trying to create.

The Convener: In light of the new variant, and given that we are trying to suppress transmission, I will mention one of the comments and one of the questions that we have received from members of the public. The comment is:

> "I work as a symptomatic Covid 19 tester. My colleagues and I find it shocking that people who come for testing will arrive with families and friends in tow. Sometimes we get full carloads. Usually none are wearing masks and it is obvious they have been to a drive-in fast food outlet before attending for their test. We have been told that now they have had the test 'they are taking the family out for lunch to cheer them up!'"

That brings to me to the question, which is from Geraldine from South Ayrshire. She asks:

> "What is being done to ensure people self-isolate whilst symptomatic or waiting for test results, as the message does not appear to be getting through?"

John Swinney: There are a number of points in the question and scenario that you have put to me. The first point is that a key response is the necessity of ensuring that baseline health protection measures are habitually followed by everybody in all circumstances, including when going for a polymerase chain reaction test. Important measures that should be applied include ensuring that people are wearing face coverings in the appropriate settings and following the basic hand hygiene measures. All those measures are critical at all times. Members will be aware that, in our public messaging in Parliament and in our wider public messaging through television advertising and so on, the Government is regularly reinforcing those messages.

The second point is that the greatest care must be taken by individuals when going for PCR tests. In the scenario that you put to me, if a whole carload of people from the same family are being tested, it is understandable that they are all in the car. However, I encourage only the people who need a PCR test to go, and to observe all the hygiene measures that are appropriate in such circumstances.

Finally, when it comes to observing self-isolation, the requirements could not be clearer. If an individual has symptoms or cause to secure a PCR test, or if they have undertaken a lateral flow test and tested positive, that should instantaneously bring about a change in behaviour, because that person is potentially infectious. That individual must take every care in their movements and in observing the appropriate restrictions to ensure that they minimise the risk of transmission.

I assure the individuals who have contacted the committee that those messages are uppermost in the Government's communications.

The Convener: It is crucial that we reiterate the importance of following the guidance.

Murdo Fraser: Earlier, we were discussing the omicron variant and the impact that it might have.

It is now generally understood that the best way to address the issue is to accelerate the booster vaccination programme. Yesterday, we heard about a number of incidents involving individuals who turned up at vaccination centres expecting to be given the booster but were turned away because it has been less than 24 weeks since their second jab. That was clearly not in line with the new Scottish Government guidance. Has the issue now been resolved?

John Swinney: Yes, the issue has been resolved. I very much regret that some individuals had that experience yesterday. The guidance has changed and it should have been applied in all vaccination centres and scenarios.

In light of what emerged yesterday—I am advised that the issue arose in a limited number of cases—we have reiterated the guidance to all health boards to ensure that all vaccination centres are operating to the new updated guidance, which emerged only at the start of the week.

I regret that some individuals were inconvenienced in that way. The fact that people are so willing to come forward for the booster jag at such an early stage after the change of guidance is an indication of public attitude to participation in the programme, which is welcome. That makes it doubly disappointing that people were inconvenienced in the way that they were.

Murdo Fraser: Thank you—that is helpful. You just referenced that there will be substantially increased demand for boosters. The public will be seeing the news headlines about the omicron variant and will be concerned about it. There will be a lot of extra demand. Is the capacity in place to respond to that demand? What steps are being taken to increase capacity, particularly over the coming weeks?

John Swinney: There is no issue regarding vaccine capacity. Obviously, we have to go through the process of vaccination in an orderly fashion to ensure that it is done efficiently. We have already expanded significantly vaccine availability as part of the programme.

The change in JCVI guidance on Monday increased the number of people who are eligible for a booster vaccination. If memory serves me right, an additional 1.3 million individuals immediately became eligible. Colleagues will understand that we cannot vaccinate 1.3 million people in one day, so we have to increase capacity to move through that as efficiently as possible. Work is under way to ensure that we satisfy the understandable demand that there will be in the community.

Prior to the new JCVI guidance, we were confident that all eligible individuals would be able to secure their booster vaccination before the turn of the year. We are confident that, with the new guidance in place, we will be able to reach that point by the end of January. There will be a period during which people will have to wait some weeks to secure their booster jag, but they will certainly get it earlier than would have been the case in other circumstances, such as if they had to wait 24 weeks after their second vaccination.

Murdo Fraser: That is helpful. I want to ask about the connection between the booster and flu jabs. Many people, including the over-50s—the cabinet secretary and I fall into that category—have been invited to get the booster and flu jabs at the same time. However, in some cases, that will mean that people will not have an appointment until January. Would that create an additional risk for people? The peak flu danger season is presumably in early January.

John Swinney: I will bring in Professor Leitch on part of that question, because we will get into the assessment of clinical risk. I will explain the thinking behind the programme.

This year, we took a decision to vaccinate more people than ever before for flu, and we had a commitment to administer the booster jags for a range of population groups. Our judgment was that the most effective and efficient way of doing that was to combine, as far as possible, the flu and Covid booster vaccination programmes to ensure that we were using resources wisely and calling in people when they could get two doses together. I had my flu and booster jags on Sunday, in a very efficient programme in Blairgowrie town hall.

10:45

The programme is designed to enable us to make as much progress as possible, but there will be some people who will get a flu jag slightly later in the year than they would have done under a stand-alone programme. Professor Leitch can set out the clinical issues around that.

We are trying to maximise the protection that is available to individuals and within society by having as efficient a programme as we can. I accept that some individuals might get a flu vaccination slightly later than they would ordinarily have received it.

Professor Jason Leitch (Scottish Government): The Deputy First Minister is right. I will make a couple of points about flu. There is no flu at the moment, so there is no panic. As yet, nobody needs to worry about catching flu, because the numbers—across the whole country—are in single figures, although I do not anticipate that that will last.

The flu season is later than we think it is. Most people think that flu comes with the winter. It does, but it takes a bit of time for it to spread. The real flu season for hospitals is into the new year—January, February, March and April. It is not usually in November and December. There are exceptions, but this year is not one of those. It might be the case that we will get away with having fewer cases of flu than is usually the case. That would be fantastic because, frankly, the hospitals could really live without more respiratory disease.

We will need to make a judgment about when we start to call people for a flu vaccine who have now had a Covid booster, because the Covid appointments have shifted. The appointments of people who were expecting to get Covid booster and flu vaccinations in January will probably stay in place, but if someone is to get their Covid booster in March, I would expect them to go for their flu vaccine before then.

Now that the JCVI has issued new advice, we have changed the operational plans and each board will make a judgment. Part of those operational plans relates to the flu vaccinations. We will now shift some of those forwards or backwards. It is possible that we might be able to do more joint vaccinations than we thought. That will all get sorted out at board level and people will be told.

If people are confused or worried about the situation, they can talk to their general practitioner. Their GP may well not vaccinate them, but they can at least reassure them about where they are in the process and the risk that they face.

Murdo Fraser: Do I have time to ask one more question, convener?

The Convener: We need to move on to Alex Rowley.

Alex Rowley: You said that the capacity is there and that there are no issues with it. Just as you came into the meeting, I noticed that somebody in Kirkcaldy had tweeted:

> "Turned away for my covid booster in Kirkcaldy this morning, seems the message still hasn't filtered down, wouldn't have been a big deal but the place was deserted."

There is a mismatch between what the Government is saying in this place and what is happening out there.

On Tuesday night, I went along to the drop-in centre in Dunfermline, which was open from 5 till 8. I had queued for about 40 minutes and got to the front door of the vaccination centre at about 25 past, at which point the staff announced that there were another 50 people still waiting inside and that they were going to have to stop. I was lucky and got in, but about 40 people were turned away. That suggests that the capacity is not there.

More important is the fact that, as I was told once I had got into the vaccination centre, staff had had to put up with quite a bit of abuse, because of the massive queues. The staff were brilliant; it was clear that they had never lifted their heads for the whole evening. They said that it is fine for politicians to stand up in Edinburgh and tell people to go and get their boosters, but if they are not prepared for that and the staff are not in place, there will be a mismatch and people will struggle. Where are we with that?

John Swinney: With a programme of such magnitude, there will be a phenomenal number of operational issues. We must bear in mind the numbers that we are talking about. More than 10 million vaccinations have now been undertaken. What has been achieved in the programme has been a colossal undertaking. I pay tribute to the staff who are delivering the vaccinations and those who are organising the programme, because it is not a simple logistical exercise.

Mr Rowley raised several points that need to be addressed, the first of which relates to the tweet that he mentioned. We have reiterated the guidance to health boards, and it is important that that guidance is applied in all scenarios and circumstances on the ground. I will take away the fact that an example has been raised with me where that message has clearly not reached all the distribution points for the vaccination programme. Obviously, there has been a change of circumstances and the advice is relatively new, and it takes time for those messages to be put across. However, I will make sure that the issue that Mr Rowley raised is taken up.

The second point concerns the capacity questions. When I answered Murdo Fraser, I said that there was certainly capacity in terms of the availability of vaccines. There is adequate provision of vaccines; the question is about the best means of administering the programme at a local level. Of course, there is a range of options for how we might go about doing that. There are probably three main options: a drop-in service; self-selection of appointment via the online portal; and setting appointments via letters from health boards.

There are upsides and downsides to each option. For example, sending out letters gives an order and an organisation to the programme, but the downside is that it takes time to get the infrastructure in place to administer and distribute the letters, and there will be a reasonable level of did-not-attends.

The portal option, which we are using, can give people a choice about when their appointment is. I

was able to choose to go to Blairgowrie town hall on Sunday morning, which suited me down to the ground, and I have now had my vaccination. However, for some people, digital access is a challenge and other people might find that they cannot find an appointment that suits their choices.

The drop-in option, as Mr Rowley has recounted, can be quite challenging if too many people decide to drop in at the same time. The vaccination centre in Kirkcaldy was quiet this morning, as we heard from the member of the public whose tweet Mr Rowley quoted, but the vaccination centre in Dunfermline that Mr Rowley went to on Tuesday night was busy. The smoothing of demand is difficult with a system that has only drop-in appointments.

We have tried to opt for a means of balancing out the best of those options as far as possible. When I went on Sunday morning for my vaccination, the couple after me were drop-in candidates. They were not in a different queue; they were right behind me and they got taken right after me.

We are trying to work through every possible practical permutation to maximise access. Obviously, if the 1.3 million people who are now eligible for a vaccine decide to drop in for a vaccination today, there will not be adequate places. We are therefore trying to balance the vaccination programme over the country with a number of mechanisms to enable us to maximise participation in it.

Alex Rowley: There is a lot that we do not know about the latest variant. What we seem to know, based on the evidence that is coming out of South Africa, is that it spreads quickly, which is a massive worry to scientists. The evidence suggests that it can spread much more than the delta variant, which was bad enough.

Given that fact and the fact that people are being turned away when they go for their booster jag because the capacity does not exist, do you agree that the Government needs to look at what is in place in each health board area and see what needs to be put in place? The other day, the Cabinet Secretary for Health and Social Care was on the radio saying that there would not be enough staff to increase the capacity, because we cannot bring in staff from other parts of the national health service. What else needs to be done? What other professions can be quickly trained to provide the capacity? Based on the evidence that we have seen to date, we need mass vaccination to happen as quickly as possible.

John Swinney: We have a mass vaccination programme, which is under way. We are distributing in excess of 60,000 vaccinations daily in Scotland. We are the most vaccinated part of the United Kingdom, with the highest levels for first, second, third and booster vaccinations. We have a comprehensive mass vaccination programme.

The Government is looking at the situation from health board to health board, and the health boards have submitted plans to intensify the vaccination programme. Dialogue continues between the Government and health boards to maximise that capacity. The programme must take place in a variety of geographies and scenarios across the country. I assure Mr Rowley that we are trying to maximise the capacity of the vaccination programme, but he must accept that there is a challenge.

The two pieces of information that Mr Rowley has just given the committee highlight that challenge: before 11 this morning it was quite quiet at the Kirkcaldy vaccination centre, but last night, between five and eight o'clock at the Dunfermline vaccination centre it was very busy. That illustrates the challenge of operating such a programme. We are providing capacity. In Kirkcaldy this morning, drop-in appointments could be fulfilled because it was quiet, but in Dunfermline on a Tuesday night that becomes more problematic. I assure Mr Rowley that every step is being taken to maximise the programme.

Professor Leitch has been involved in work to expand the pool of individuals coming forward to deliver the vaccination. I will ask him to say a bit about that in a moment. The more that we draw in people from within the health service from other disciplines to administer the vaccination programme, the more that we will have to address the issue of what other services the national health service can deliver. If, to deliver the vaccination programme, we draw in healthcare staff who usually deliver elective activity, we will obviously reduce the capacity for the elective work of the national health service. I know how much it matters to the public and to members of the Parliament that we do as much elective work as we can. Jason Leitch might need to get more detail on that.

Professor Leitch: Mr Swinney has covered it well. It is a real balance. To put it in context, we are vaccinating people faster than we have vaccinated in history. It is the fastest that any country in the world is vaccinating, apart from possibly the Republic of Ireland last week. We have put out recruitment calls for every board for anyone who can help us, from medical students through to optometrists and dentists.

Earlier this week, I made a private visit to NHS Greater Glasgow and Clyde's human resources department, which is in the old Yorkhill hospital,

just to meet the staff and thank them. They have been overwhelmed by the response to the most recent advert. A new set of individuals have been recruited, but it takes a bit of time to get those people on board, depending on their history, whether they have done vaccination before and whether they are a clinician or a student. That is going well and those people will be put into the shifts as quickly as possible.

Glasgow has vaccination centres throughout the city and the broader health board area, which are running every day. Drop-in clinics are awkward for us, for the reason that has just been described. Logistically, we would rather that people had appointments so that we know when they will come and so that there is an order. That would allow us to plan the next two months to vaccinate 1 million to 2 million individuals with the Covid booster.

Mr Rowley and Mr Fraser are both right that vaccination is, in Mr Fraser's words, the best way to fight omicron, but it is important that we understand that it is not the only way to fight it. I know that this is not what you are suggesting, but we should not just think about vaccination. Of course, we need to vaccinate, and tens of thousands of people—staff and citizens—are being vaccinated today in vaccination centres, but we also need to think about how we protect the population from omicron in other ways.

11:00

Jim Fairlie: I will talk about vaccine uptake and where there is a bit of hesitancy. My points come from questions that members of the public have put to the committee.

A number of people have been in touch about women's reproductive health and the vaccine. Some are asking whether fertility is impacted in any way by having the vaccine. I know that we have covered that before but, if we are getting the questions, it is clear that the message still has not got out to some individuals.

Others have asked whether breastfeeding women will be eligible for the booster vaccine, and whether health and social care partnerships and midwives have appropriate information and training on eligibility for the vaccine. Parents have highlighted that there is inconsistency of knowledge and understanding in HSCPs across Scotland in relation to breastfeeding and vaccine eligibility.

Finally, I have a constituent who is very concerned about getting the vaccine because she is on cancer drugs. I ask Jason Leitch to comment on that.

John Swinney: It would be best if Professor Leitch responds to those.

Professor Leitch: Let me be as blunt as you would expect. There is no contraindication, at all, to the vaccine if someone is pregnant or breastfeeding. There is no biologically plausible mechanism for the vaccine to cause them any more challenge than if they were not pregnant or not breastfeeding. Is that blunt enough?

If people do not believe me, they can head to the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health or any trusted source of clinical information, including our own NHS inform. Young Scot has really good information for young people to help them to make those choices.

It is important that we do not suggest that vaccination is always an easy choice for people. The vaccination centres do not force people to be vaccinated. In fact, one reason to go to a vaccination centre might be to have that conversation. People can leave unvaccinated—nobody will force them to be vaccinated—but the best people to have that conversation with may well be the senior clinicians who are in that vaccination centre in Kirkcaldy, Dunfermline or wherever. They are well equipped. If the individual in the centre is not able to answer more technical questions—on cancer drugs, for example—we have escalation processes in place in the centres, and by phone to even more senior immunologists, virologists and others, where someone would be able to get all the information that they require. Tiny numbers of people might have to be given a reappointment in a specialist centre, but that would affect very small numbers.

For Jim Fairlie's constituent who is on cancer medication, it depends what that is. If it is long term, there is probably no risk, but the best answer for them is to talk to the care team that is looking after them, who will be able to point the constituent in the right direction. It is vanishingly rare for people not to be able to be vaccinated, even during cancer care. However, there are some who cannot be, so Mr Fairlie's constituent should check with the care team whether it is safe to be vaccinated.

Jim Fairlie: As I said, I know that we have been over the issue before, but it is worth re-emphasising.

Professor Leitch: It is important. We are seeing a number of pregnant women across the UK fall ill with Covid—proportionately more than we would expect if it were random. In the UK and around the world, pregnant women are falling ill with Covid because they are choosing not to be vaccinated. That is a much bigger danger than the vaccine.

Brian Whittle: When the committee spoke to experts this morning, I suggested that the emergence of omicron was expected—mutations of the virus were expected. I asked how we manage that continual process, but the response of the experts was that omicron matches the worst-case scenario modelling that they have done, which was not what I wanted to hear.

Professor Leitch: Nor did we, to be clear.

Brian Whittle: I know. That changed how I will ask my questions. The scientific and medical communities are examining the impact of omicron on transmission, the severity of the condition and vaccination effectiveness. How are you considering what measures need to be taken while we wait for that information, given that, as one of my colleagues said, it is likely that transmission rates will increase, which could put stress on the NHS? We have heard that the number of cases in South Africa has gone in two weeks from a few hundred a day to more than 8,000 a day. It will take a little time to find out the exact impacts. Where are we with the thought process?

John Swinney: You raise the fundamental dilemmas that we wrestle with all the time. That is why I said in my opening remarks that we are taking a proportionate and precautionary approach to handling the situation.

Modelling of the pandemic's likely course is undertaken regularly, and a variety of variables are considered. A few weeks ago, the modelling looked at the potential impact of the 26th United Nations climate change conference of the parties—COP26—and it has covered the impact of winter and all sorts of scenarios.

The modelling gives central, better and worse scenarios, on the basis of the virus's prevalence and circulation. We hope for the better scenario, we prepare for the central scenario and we hope that we do not reach the worse scenario. Different actions are required if we face the better, worse or central scenario. That is why I used the word "proportionate" in talking about our judgment.

The precautionary approach is important, too. If we look at the pandemic today in Scotland, we see that case numbers are high but fairly flat. The figures for the past seven days are slightly down on those for the previous seven days. The hospitalisation rate of Covid patients today is slightly lower than it was, although the figure is still more than 700. If those 700 people were not in hospital with Covid, we could provide other treatments for 700 patients.

There is a careful judgment to be made about the proportionate steps to take. If omicron turns out to be more transmissible than delta, there will be more cases. If the level of serious illness from omicron is no different from that of delta, a relatively small percentage of cases will be hospitalised, but that will involve more people if the number of cases is higher. That will place even more pressure on the national health service and will mean that services are under pressure.

If the level of serious illness does not change but the volume changes significantly, we will have to take more dramatic action. I have no justification for that today because, although I can look at the omicron scenarios, a compelling evidence base does not yet exist for taking more severe measures. It might well exist in the future, so the Government will keep the situation under constant review.

Professor Leitch: The expert whom Brian Whittle cited is correct. Omicron looks terrible down a microscope. It has mutations that we know are linked to vaccine escape, it has mutations that we know are linked to increased transmission, and it has new mutations—we do not know what they do, in rough terms.

We do not know how omicron will perform in the real world. Virologists talk about the fitness of a virus, to summarise what it can do. We do not know whether omicron will be fitter than delta in the long term. If it is fitter than delta, we can only slow it—we will not be able to stop it—and it will overtake delta, which has become the dominant virus around the world.

We must do, and have done, two things. We must try to stop omicron coming here and, when it is here, we must manage it as we managed the original virus—you will remember that we tried to put a ring of steel around cases. When the first outbreaks took place in Coupar Angus and Gretna, we really focused on them.

We are dealing with two simultaneous pandemics just now. Health protection teams are dealing with delta in ways that are fully understood by the committee—they involve restrictions, testing and vaccination—but at the same time we are trying to control the new omicron pandemic in a much more targeted way, with enhanced contact tracing and enhanced PCR testing.

If omicron is worse than delta, we can only slow it down. We cannot stop it or hope that delta stays and omicron goes away. That will happen only if it is not as fit as delta. We need to know omicron's impact on three things: transmissibility, severity of disease and vaccine escape. We can tell some of that from looking down a microscope, but for most of it we need real-world data. For every 10,000 delta cases, roughly 3 per cent go to hospital and 1 per cent die. What are the percentages for omicron? Are they 3 per cent and 1 per cent, too, or are they, say, 4 per cent and 2 per cent? That is a massive difference, but we just cannot tell yet.

The early signs from South Africa are bad. It took 100 days for delta to be the dominant variant there, whereas it has taken omicron only 20 days. That suggests increased transmissibility, but we just do not know. The population in South Africa is much less vaccinated than ours and the demographic is different and younger. We cannot make exact extrapolations to our context, the Japanese context, the Californian context and so on.

We need more time. In fact, the sentence that I probably say most often—indeed, every day—to the Deputy First Minister is, "I need more time." Sometimes, we just do not have the time, so we have to make proactive decisions before we get all the data.

John Swinney: That last point completes the proportionality argument. At some point, we have to make a call that, on the basis of the best clinical assessment that we can get of the three factors of vaccine escape, transmissibility and serious illness, this is the moment to act. I accept that we might not have all the demonstrable evidence—or, indeed, the conclusive certainty—to support such a conclusion, but the fact is that the Government has been making such judgments since March 2020.

Brian Whittle: That was really helpful, and it leads me on to a point that I raise reasonably regularly. The committee is looking at holding an investigation into the number of excess deaths in Scotland, which is currently sitting at 12 per cent above the average. Those are not all Covid-related deaths. With the emergence of omicron, the question of how we take such decisions becomes even more acute. After all, there is mortality associated with other non-Covid-related conditions. We will have a look at that at some point, and I am sure that the medical profession is already looking at it much more deeply than we will, but—I know that I keep looking ahead—how do we strike a balance and find a route that allows us to get back to some normality with regard to other conditions that have mortality associated with them?

John Swinney: That is a very significant and legitimate question. In my answers to Mr Rowley's completely legitimate questions about expanding the scale of the vaccination programme, I made the point that one of the options could be turning down the dial on elective work and putting more resource into the vaccination programme. If I do that—I do not wish to personalise this, but I will use these distinguished members of Parliament to illustrate my point—Mr Rowley might be more happy, but Mr Whittle will not be. Mr Whittle's primary concern is the treatment of what I will call non-Covid conditions that are perhaps leading to early mortality because health services are unable to undertake all that we would ordinarily hope they would be able to.

That is why we have to invest in all the precautionary measures possible to avoid the virus circulating. We are not in any shape or form powerless with regard to omicron circulating, because people can come forward for vaccination, which they are doing in substantial numbers, and they can observe the baseline measures on a routine and rudimentary basis in order to put up barriers to circulation.

There are all sorts of steps that we can take. It is incredible to watch what our contact tracers are doing in response to the early cases of omicron. It is jaw dropping to see the degree of intensity with which they are looking at where people have been, whom they have been close to and what is happening around them, to try as much as possible to interrupt the circulation of the virus.

We have to use a variety of devices because, the more we do that, the more activity we will have to try to address the core point that Mr Whittle puts to me.

11:15

The Convener: Can we move to John Mason, please?

John Mason: Thank you very much, convener. We could all do with more time.

Because I was getting my booster vaccine after six months, I thought that I had been safe for six months. I got it on Friday. However, now, the gap is three months. That sends out the message that people are at risk after three months. Is the vaccine protection waning more quickly than we thought? Will we have to get a vaccine every three months?

John Swinney: I will bring in Professor Leitch because of the clinical nature of some of the points.

Obviously, the vaccine will wane. Over the past few weeks and past two months, there was an increase in cases in the older age groups. Then, when the booster vaccination programme started to kick in for those age groups, the number of cases for them came down more aggressively than for other age groups. Professor Leitch can tell me if I have got this wrong, but I deduce from that that the vaccine was waning but the booster arrested that and gave more protection.

John Mason: The logic of that would be that we should have the booster after two months.

John Swinney: Clinical points might mean that there is no justification for doing so because there may be sufficient vaccine protection for a sufficient length of time. The disease is new, so clinicians

and scientists are trying to work their way through to the best answer. Their judgment was that the gap should be six months. The JCVI has revised that to three months.

John Mason: Going from six months to three is quite a dramatic fall.

John Swinney: It is but, to go back to my two key words—proportionate and precautionary—it is also a recognition that, in the light of omicron, it is necessary to take the precautionary stance of moving to an earlier time for the booster jag. That strikes me as a rational decision for the JCVI to arrive at.

Perhaps Professor Leitch will want to add something.

Professor Leitch: I will add a few things—I will try to be quick.

Remember that the JCVI advice is that the booster jag should not be given before three months, not that it should be given at three months. Before that, the advice was that it should not be given before six months. The JCVI knows that we cannot do everybody on the Tuesday night that it issues its news release. The JCVI is smart and knows that we need a bit of run-in time to get everybody.

My booster is on 17 December, which will be 26 weeks from my second vaccination. I could have brought that forward, but I am going to go on 17 December. I figure that 10 days will not make that much difference. I might live to regret that, but it is my present position.

I will try a metaphor. Immunity is not like an on-off light switch; it is like a dimmer light switch. I cannot tell what your dimmer is doing and you cannot tell what mine is doing. At a population level—looking at the number of infections and hospitalisations across the whole world and looking at the vaccine that we used, how well it went and which age groups we vaccinated—the boffins can say, "Oh, Scotland's dimmer has reduced, so we need to turn it back up again." The way to turn it back up again is to boost from the oldest all the way down to the youngest. They have to take into account the fact that we had a large gap between vaccinations 1 and 2. Israel did not and its immunity waned first, so it looks as though vaccinations wane.

The next thing that will happen is that we will watch the dimmer again. Immunologists tell me that it will dim less the next time because your body remembers. Each time you get a vaccination, immunity stays higher for longer. Immunity is complicated. It is not just about antibodies—there are also cells remembering things. It may well be that the next booster might be a little further out, and the next one after that might be further out again. Alternatively, we might say, "We'll only do the elderly next time," because for young people, their imprint has stayed on for longer. However, it is all quite difficult, because we have to take serial blood tests from people to check that they have immunity and then watch the whole population to see how the dimmer is working. If we need to turn the dimmer back up again, we vaccinate from the top to the bottom.

John Mason: Could we expect new vaccines to give longer protection?

Professor Leitch: We absolutely could, principally around new variants. Again, variants are not like a binary light switch. Omicron will not escape the vaccine completely, but it might give—I am completely guessing here—60 per cent protection rather than 95 per cent, in which case we would probably want to adjust the vaccine for next year. The companies say that they can do that within 100 days—they can produce the vaccine, and we would have it within approximately six months from start to finish. We are not only turning the dimmer up but making it more efficient. We can turn up it faster, because we have got it acting against the one that we want it to.

I think that I overstretched that metaphor a bit.

John Mason: No, I get the point—that is helpful. It is not black and white; that is pretty clear.

On the question of vaccine certificates, from Monday—if I am right—a negative test is going to be allowed, possibly along with some other variations. Will that appear on the app or the certificate?

John Swinney: No, the lateral flow test will not appear in the app.

John Mason: The lateral flow test will not appear. What about the booster? A constituent has been in touch with me to say that, when he goes to Germany, they will want to see a recent jag.

John Swinney: The app has been revised to include the booster jag; we expect that to be completed and the update to be available in early December. A critical date is 15 December, when a number of European countries will make it mandatory for booster jags to be evidenced on Covid vaccine certificates, and the update will be in place by then.

Elizabeth Sadler (Scottish Government): The app will be updated for international travel and boosters from 9 December; it will take longer for the app to be updated to include boosters for domestic certification. The current domestic certification scheme defines "fully vaccinated" as

having had two vaccines, and it does not currently include a requirement for a booster.

John Mason: That is helpful.

Finally, what about children aged from five to 11? Are we thinking of vaccinating them?

John Swinney: We are awaiting advice on that point from the JCVI, which has been exploring the issue—

Professor Leitch: Every week.

John Swinney: We will look carefully to the recommendations that come from the JCVI in that respect.

The Convener: That concludes our consideration of item 2. I thank the Deputy First Minister and his officials for their evidence.

Item 3 is consideration of the motion on the expedited draft affirmative instrument that we considered under the previous agenda item. Members will note that Scottish statutory instrument 2021/425 was laid on 19 November, and we had intended to take the motion on the instrument at this meeting. The Delegated Powers and Law Reform Committee has decided to consider the instrument at its meeting next week, so we will defer consideration of the motion.

Deputy First Minister, would you like to make any further remarks on the draft affirmative instrument on the vaccination certification scheme before we take the motion?

John Swinney: No, convener—I am satisfied with what I have said.

The Convener: I invite the Deputy First Minister to move motion S6M-02332.

Motion moved,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 4) Regulations 2021 [draft] be approved.—[*John Swinney*]

The Convener: Are there any comments from members?

Murdo Fraser: I had hoped to make this point in the earlier session, but time ran away with us. I draw to the Deputy First Minister's attention the comments that have been raised with this committee by the DPLR Committee, which considered the instrument on Tuesday.

The instrument that is before us allows for the use of a negative lateral flow test as an alternative to vaccine certification for entering certain premises. That is a welcome step—it has been welcomed by the business community, and it brings Scotland into line with most, if not all, other European countries that operate a vaccine passport scheme.

However, the DPLR Committee raised the issue that the change, in effect, relies on individuals' honesty, because it will be relatively easy for someone, if they want to, to present a false negative test. The DPLR Committee asked the Government whether it had considered that and whether it had given any thought to making the system more rigorous, for example by introducing sanctions for people who present a false negative. I do not know whether the Deputy First Minister can respond to that, or whether he has any thoughts on that point on behalf of the Government.

Jim Fairlie: May I make a point, convener? That would not be a false negative; it would be a fraudulent negative.

John Swinney: I think that members of Parliament have wrestled with that question for a considerable time. Indeed, Mr Fraser and a number of other members have been pressing the Government to take that step for some time.

The Government wanted to have a scheme in place that would help to boost vaccine take-up, which is why we resisted that move to begin with—it does not suit the purpose of our scheme. For completeness, however, I put on the record that, at the same time, we indicated the risk that Mr Fraser puts to me.

There is a risk here. I cannot deny that. However, the approach is part of the culture that we have to take forward if we are serious as a society about resisting the spread of the virus. We need to test ourselves and follow what the one or two red lines tell us when the test is complete. I encourage members of the public to take the process deadly seriously, and I know that many are doing so. There is very high demand for lateral flow tests, thankfully.

I return to the questions that the convener put to me at the beginning about how seriously people are taking the testing approach. Testing is a very important tool in stopping the circulation of the virus, and it would not be right for somebody to report a test result that was inaccurate. If Mr Fairlie will forgive me, I am not sure that it is for me to decide what is fraudulent and what is not, but that would not be the right thing to do, because it would undermine the purpose of the scheme and the taking of the test. I encourage members of the public to test and to report the findings accurately.

Jim Fairlie: I will be brief because I have to go to the chamber, but I will comment on my use of the word "fraudulent". Christmas is coming up, and if someone who is 18, 19 or 20 is going out with their mates and they do not feel bad but their test comes up positive, they might just chance their luck because they feel okay. I have a genuine

concern about that. That has always been my concern about going down this road.

John Swinney: I accept those points and that is why I make my plea to people. I do not think that it is just 18 and 19-year-olds—

Jim Fairlie: Yes—we should not demonise that age group.

John Swinney: It is everybody. Personally, I am now undertaking lateral flow tests much more frequently. I was doing them twice a week, but I am now doing them much more frequently because of the degree of interaction that I have in the course of my work. I have no social life, but—

Professor Leitch: That is not pandemic related. [*Laughter.*]

John Swinney: That is nothing new. However, I am taking tests more frequently because of the degree of interaction that I now have in the course of my responsibilities.

The Convener: Thank you. I am conscious of the time. Are members happy for me to put the question on the motion?

Members *indicated agreement.*

The Convener: The question is, that motion S6M-02332 be agreed to.

Motion agreed to,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 4) Regulations 2021 [draft] be approved.

The Convener: The committee will publish a report to the Parliament later today setting out our decision on the regulations. That concludes our consideration of this item and our time with the Deputy First Minister. I thank him and his supporting officials for their attendance this morning.

The committee's next meeting will be on 9 December, when we will take evidence from stakeholders on the vaccination programme.

That concludes the public part of our meeting.

11:29

Meeting continued in private until 11:33.

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