OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 28 April 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 28 April 2022

CONTENTS

COVID-19 RECOVERY COMMITTEE

13th 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)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 28 April 2022

[The Convener opened the meeting in private at 10:00]

10:26

Meeting continued in public.

Decision on Taking Business in Private

The Convener (Siobhian Brown): Good morning, and welcome to the 13th meeting in 2022 of the COVID-19 Recovery Committee. I have received apologies from Brian Whittle MSP.

Agenda item 1 was taken in private. Item 2 is a decision on whether to take in private item 6, under which we will consider our approach to the committee's communication of public health information inquiry. Do members agree to take item 6 in private?

Members *indicated agreement.*

Covid-19 Update, Coronavirus Acts Reports and Subordinate Legislation

Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 6) Regulations 2022 (SSI 2022/123)

10:26

The Convener: Under item 3, the committee will take evidence from the Scottish Government on a Covid-19 update, two-monthly reports to the Scottish Parliament and subordinate legislation. I warmly welcome to the meeting our witnesses from the Scottish Government: the Deputy First Minister and Cabinet Secretary for Covid Recovery, John Swinney; Professor Jason Leitch, national clinical director; and Elizabeth Blair, Covid co-ordination unit head. Thank you for your attendance this morning.

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

The Deputy First Minister and Cabinet Secretary for Covid Recovery (John Swinney): I am grateful to the committee for the opportunity to provide a short update on Covid-19.

We have now reached a stage at which all legal restrictions relating to protective measures have been lifted. Although Covid has not gone away, that is a positive and welcome step in the right direction.

Through guidance, the Scottish Government will continue to recommend that people take a proportionate and risk-based approach to reducing the likelihood of getting or transmitting the virus. For example, our advice remains that it is sensible to continue to wear a face covering in some public indoor spaces and on public transport.

Getting vaccinated and receiving a booster vaccine remain the most important things that any of us can do to protect ourselves and others. The vaccination programme is continuing at pace.

In line with our test and protect transition plan, and informed by advice from public health officials and clinicians, we are adapting our testing programme to support the effective management of the virus as it becomes endemic. For example, although regular lateral flow testing is no longer recommended for the general public, some groups will remain eligible for free lateral flow testing. That includes unpaid carers and people who are visiting a hospital or care home.

The Scottish Government's revised strategic framework will continue to inform our approach to managing the virus in the longer term. The

framework of threat levels and potential responses provides as much clarity as possible for planning purposes while retaining crucial flexibility to ensure that any necessary responses are effective and proportionate. We will continue to monitor the prevalence and risk of new variants to ensure that we can respond to outbreaks and future health threats.

As we welcome the proportionate changes to our pandemic response, the Scottish Government continues to focus its efforts on supporting Scotland's recovery and creating a fairer future for everyone—especially for those who have been most disproportionately affected during the pandemic. Our Covid recovery strategy sets out an ambitious vision for recovery that is shared by local government. Alongside the president of the Convention of Scottish Local Authorities, I am overseeing a programme of activity that will increase the financial security of low-income households, enhance the wellbeing of children and young people, and create good, green jobs and fair work.

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

The Convener: Thank you very much, Deputy First Minister.

We have around 50 minutes for this agenda item, so members have approximately 10 minutes each for questions and answers. Everybody should keep that in mind, please.

I will ask the first question. Yesterday, it was announced that the highest-risk list is to close on 31 May. I appreciate that the success of the vaccination roll-out means that the vast majority of people on the list are at no greater risk than the general public, but there are still people out there who will be concerned by that announcement. Was any public consultation done on that?

10:30

John Swinney: Obviously, we speak to a variety of interested parties about their concerns and anxieties about changes of such a nature but, fundamentally, we need to take an approach that is based on the evidence and the clinical advice that is put to us. You make a valid point about the degree of risk to which individuals are exposed, given the degree of protection that is now in place through the vaccination programme, which will be at a greater degree of intensity for people who have been at higher risk than it will be for others in the general population.

In addition, ministers must wrestle constantly with the question of proportionality, to ensure that our actions can be justified as being proportionate. With any requirements, measures or mechanisms that we have in place, such as the measures for people who are at higher risk, we must be satisfied that they are proportionate to the risk that those individuals face. We must also be satisfied in relation to the degree to which any impact on the wider population is proportionate.

We wrestle with such questions constantly to ensure not only that we are taking the necessary steps, but that those steps are appropriate in the context that we face.

The Convener: Thank you—that is helpful.

An issue that I have brought up previously is that of how we can raise awareness of the distance aware scheme. I will share my experience. After raising the issue in the committee, I went to Asda in my constituency and was told that it no longer does the scheme. When I went to Morrisons, the staff did not know what I was talking about. I then went to one of the local libraries. The staff found a box, said, "I think this is what you're talking about," and gave me a lanyard. When I asked whether there was a pass or a badge to go with it, they said, "No—you just get the lanyard." Therefore, I think that there is still a lot of work to be done, especially for those people who want other people to keep their distance and still have concerns about going out among the general public. We need to raise the general public's awareness of the need to respect the space of such people.

How can the Scottish Government raise the profile of the distance aware scheme?

John Swinney: We have undertaken quite a significant amount of communication about the scheme but, from your anecdotal experience in your constituency, it is clear that we have not reached all parts of the community. The Government's work has been supported by the work of a range of statutory organisations, including our health boards, voluntary sector organisations and local authorities, which have been heavily involved in the scheme's promotion in localities.

Your question gets to the nub of a genuine difficulty that we face in the context of where we find ourselves in relation to Covid at the moment. In general, people are desperate to move on—they are desperate to think that Covid is all done and dusted. I completely understand that sentiment. However, for some members of the public, measures such as the distance aware scheme are an essential component in assuring them of their personal safety and security.

However good and effective public communication campaigns might be, we must be aware of the fact that we are swimming against a tide of opinion, whereby many people do not want to be troubled by some of the issues in question

again. That is not an argument for not doing things such as the distance aware scheme; it is an argument for recognising that the scale of the challenge might be greater than it was before.

I will take away the feedback that you have shared and raise with the teams that are working on the messages on such matters the importance of ensuring that those messages are delivered effectively.

The Convener: That is great—thank you. I appreciate that.

What is the Scottish Government's assessment of current and forthcoming pressures on public services such as the health, police, fire and education services as a result of Covid-related absences?

John Swinney: In all the available data, we see a declining prevalence of Covid. On the last data available, the estimated prevalence of Covid in Scotland in the Office for National Statistics infection survey was one in 19 in the population. I remind the committee that, on one of the previous occasions that I was here, we were at one in 11, so there is a significant improvement in that respect. Secondly, the waste-water sampling indicates a declining prevalence of Covid. Those are probably the two most reliable current mechanisms, given that there have been significant changes to the testing arrangements. Although the test numbers show a decline, those numbers are not as reliable as they were in the past when we had a more comprehensive testing regime in place.

I share that detail with the committee to indicate that we are in a stronger position in terms of population health than we have been over the past period, particularly the past three months. Therefore, that will have a beneficial effect on the availability of staff in the critical services to which you referred, convener. It is obvious that our public services have faced a range of challenges because of the availability of staff over the past few months but, with the improving position on the pandemic, there is an improvement in the availability of staff.

The Convener: Lateral flow tests will be provided free only when there is a requirement to test. Who funds that—is it the Scottish Government or the United Kingdom Government—and what is the projected cost?

John Swinney: All those costs will be met within the assessment of the health budget that we undertake in Scotland. That number, of course, is constructed significantly by funding decisions that are taken by the United Kingdom Government about health provision in England, for which we receive consequentials. Although the total budget position will be informed and framed by funding decisions in the rest of the United Kingdom, we are, of course, free to take our decisions about how significant that programme is.

The committee will be aware that our decisions will be significantly framed by decisions in the rest of the UK because we have other health issues with which we have to wrestle. Mr Whittle is not here but he persistently presses me—understandably—about the need to ensure that other health conditions and circumstances are addressed. We cannot just ignore those issues as we take our decisions.

I do not have the number for the allocated budget for lateral flow testing in the front of my mind but it will be somewhere in my papers and, if I get to it in the course of the meeting, I will share it with the committee. If not, I shall write to the committee to inform it of the number.

The Convener: That is great. Thank you very much.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. I will raise a couple of issues arising from my constituency mailbag but, before that, I will ask about an issue that has been in the news this morning: the transfer from hospitals to care homes of individuals who were not tested for Covid who then died from Covid or potentially infected others with it.

Yesterday, the High Court in England determined that such practice was unlawful there. That relates to England, and the precedent does not necessarily impact on the Scottish courts, but it is clearly the subject of a great deal of discussion and public interest. Does the Scottish Government have a reaction to that High Court judgment? When might you be likely to respond on that question?

John Swinney: First, I acknowledge the seriousness and significance of the issue, which matters to many people in our community who lost loved ones in care homes. I express my deep regret and sympathy to everyone who has been affected by the loss of a loved one in a care home. That sense of loss is felt by us all. I acknowledge the issue's significance and the need for an appropriate exploration of all these questions.

Secondly, as Mr Fraser has highlighted, we are talking about a judgment in an English court on English circumstances and regulations, so it is not directly comparable with the situation in Scotland.

Throughout the Covid pandemic, we have taken decisions that have been designed to protect the public, particularly people with vulnerabilities, to the greatest extent possible in the sphere of a pandemic. That sentiment and approach have guided our decision making in that respect. We will, of course, consider carefully the issues that

are raised by the judgment. Beyond what I have said already, that will be the subject of further consideration.

However, consideration of the matter is already taking place. The committee will be aware that the Crown Office and Procurator Fiscal Service is undertaking an inquiry on the question, and it would be inappropriate for me to speculate on any material that it might be considering. There is explicit provision to consider the matter within the remit of the Covid public inquiry that Lady Poole is convening. She will take evidence on that question as part of the inquiry.

I am not sure that the Scottish Government can say much about a decision in a different jurisdiction on a different basis. However, I reassure members of the public that the issues that lie at the heart of yesterday's judgment in England will be scrutinised fully by both the Crown and Lady Poole in her inquiry. For completeness, I should say that, although the issue of transfer to care homes is part of Lady Poole's inquiry, it is for Lady Poole to determine how the issue is pursued, given the inquiry's independence.

Murdo Fraser: That is a very helpful and comprehensive assessment of the situation, but I seek clarity on the relationship between Lady Poole's inquiry and other issues that you have highlighted. Clearly, it is open to private individuals to pursue litigation against the Scottish Government—in fact, litigation might already be in train. Does the Government expect to wait until Lady Poole has reached some conclusions on the matter before taking a decision on how it responds to potential litigation? If so, what is the likely timescale for that?

John Swinney: Mr Fraser will appreciate that there is a hypothetical element to his question. Decisions relating to litigation would be taken in the context of that litigation. Wider consideration of such issues that might be relevant to the inquiry that is being conducted by Lady Poole would be a matter for her; it would definitely not be for ministers to take or express a view on that. In a sense, I would separate those questions entirely. If litigation comes, it will have to be addressed, but any implications of such a situation would be for Lady Poole to determine, as part of her independent judgment.

Murdo Fraser: Do you have a sense of when Lady Poole is likely to report on such issues?

John Swinney: I do not. Lady Poole is actively preparing the inquiry. I met her on Tuesday, when she updated me on the careful work that she is doing to put in place the foundations for the gathering of information that she needs to look at, some of which is already being gathered; how she will engage in public dialogue and consultation; and, obviously, the conduct of the inquiry. It is entirely for Lady Poole to determine those questions.

10:45

Murdo Fraser: Thank you—that is helpful.

I want to ask about two specific constituency issues that have been raised with me. The first relates to access to the second booster, which is currently available for individuals in vulnerable groups. A constituent of mine—Mr Nolan from Dunfermline—is undergoing chemotherapy. He was offered a date for his second booster by NHS Fife, but his consultant advised that he should not take it up at that point because of the interrelationship between that and his chemotherapy. However, the consultant suggested another date some days later when he could have it. Mr Nolan called the NHS helpline to try to shift his appointment but, for whatever reason, the call handler was unable to accommodate that request.

I might be wrong but, as far as I can tell, there does not seem to be any drop-in provision for the second booster. Is there some way in which individuals such as Mr Nolan can easily rearrange appointments? At the moment, that does not seem to be happening.

John Swinney: I would rather address the question that Mr Nolan has raised through the route of rearrangement of the appointment on the basis of clinical advice, which I know from other experience is happening. The circumstances that Mr Nolan faces are not particularly different from the circumstances of many other people who have other clinical treatments and where the clinical advice is that they should continue with the treatment that they are getting—for whatever non-Covid issue it is—and get the benefit of the Covid booster vaccination at a different time. That is not an uncommon situation, so I am troubled to hear that, on the basis of that clinical advice, Mr Nolan was not able to readily rearrange his appointment.

That would be the more appropriate and reliable route, rather than having drop-in provision, which might or might not be available. I have previously gone over with the committee some of the challenges of drop-in provision. I would much rather that the circumstances of people such as Mr Nolan were addressed by rearrangement. If Mr Fraser would like to drop me some details about that, I will see what can be done to address the issues.

I ask Professor Leitch whether he would like to add anything.

Professor Jason Leitch (Scottish Government): That is a mistake that should not

have been allowed to happen. People are now going on holiday and so sometimes cannot go for their appointments. It should be simple and straightforward to rearrange an appointment, and I am sorry that Mr Nolan has had to go round the houses a little.

On drop-in provision, the situation is not binary. Such provision is available on some of the islands, for instance, where it is the most appropriate approach. In other places, because the over-75 community, in the main, prefer appointments, we have largely stuck with the appointment system, rather than setting up units that are not very busy.

We can certainly fix the issue for Mr Nolan and anybody else who is in that situation.

Murdo Fraser: Fine. I will write to the cabinet secretary with the details.

I have one more question on a different matter. A number of constituents have raised with me the issue of hospital visiting. It seems that some hospitals have different visiting policies. Some say that, where there is Covid, visiting is allowed only in an end-of-life situation. Other hospitals say that only one nominated person may visit, except in an end-of-life situation, when more can come in. Is the matter subject to national guidance, or is it simply down to each individual hospital or national health service board to work out their own approach?

John Swinney: I invite Professor Leitch to give more detail to my response. The policy might vary from site to site because, essentially, we have tried to encourage hospitals to undertake an approach that is as safe as possible. The approach that is taken will vary on the basis of the prevalence of Covid, so there will be variation in how that is administered at sites.

My experience, which is based on what I have seen around the country, is that health boards have been endeavouring to get as close as possible to a normal but safe approach to hospital visiting, although there will be periods when specific outbreaks and challenges will make that difficult to deliver.

Professor Leitch: The answer to Murdo Fraser's question is yes, there is national guidance. However, the guidance is now slightly looser than it has been previously throughout the pandemic. The guidance is that hospitals should make more decisions locally, and that they should risk assess their buildings and Covid wards.

I have been on a bit of a tour of hospitals around the country, whether they like it or not, and the situation has varied a little. This week, I have visited University hospital Hairmyres and Raigmore hospital. In Raigmore hospital, there is still quite a lot of Covid care, which, in the main, is isolated in a single unit. That unit has a specific set of visiting instructions, but the rest of the hospital is now quite open.

For a number of reasons, Hairmyres has had quite a difficult period. Visiting had just returned on the day that I visited. It was fantastic—the cafes were open, and people were having coffee with relatives, who were also able to go into the wards.

The return of visiting is gradual. As prevalence falls, which I hope it will continue to do—at least in the short term—I hope that the transition period is relatively short and that we will go back to Scotland being one of the leading countries in the world for open visiting.

In the whole pandemic, one of the hardest things that I had to advise was the need to stop visits to care homes and hospitals. It has been really difficult for families and I, for one, am keen to get things back to where they was before, although that will be a bit of a journey.

Murdo Fraser: Thank you.

Alex Rowley (Mid Scotland and Fife) (Lab): I understand that the High Court decision in England is for England and Wales, but I think that it would be fair to accept that practices in Scotland were like for like or certainly similar to those in England. Do you agree that it is crucial that the public have confidence in any public inquiry or reviews that take place?

Although I accept that the public inquiry is independent of politicians, I was concerned this morning to read one lawyer for bereaved families of those who died in care homes say that the families do not feel that they are getting a say in the inquiry. I think that I read that families had met Lady Poole and were not satisfied with the outcome of that meeting. Do you accept that it is important that the Government plays a role and ensures that families' voices are heard, and, equally, that their questions and concerns are heard in the process?

John Swinney: Yes, I think that that is essential. I have had several meetings with bereaved families who have lost loved ones during the pandemic. It is absolutely central and fundamental for me that those families are confident about the process that is undertaken and that they have satisfactory engagement with the inquiry. That has been a critical element of the preparation of the inquiry, as I stressed in my answer to Mr Fraser. I have to be careful that I respect the independence of the inquiry, so I will simply read what Lady Poole's spokesperson said yesterday:

"Lady Poole has already met a number of different organisations representing those affected by the pandemic, including bereaved families in January 2022. These meetings have been extremely important and informative

and will help shape the Inquiry's investigations in the months ahead."

That is a very clear indication from Lady Poole and the inquiry of the importance that is attached to hearing the views of bereaved families, which I have reiterated from the point of view of the Government. It is vital that the issues and concerns that they have are properly addressed. I give my assurance that, when the remit for the inquiry is finalised, those issues will be central to its purpose, and that, although the inquiry is independent of the Government, it must address the remit given to it by the Government; that is a requirement of law.

Alex Rowley: Okay—thank you. I will move on from that specific issue related to health and social care and care homes to talk about the general state of health and social care in Scotland. We have major challenges and problems. I have been quite clear that that has been the case over a number of years, under successive Governments, so I am not pointing a finger at anyone. However, there were reports this week about care homes from the Care Inspectorate and the reality is that some of them are just not fit for purpose.

We have a social care sector in which care homes are in difficulty, and we have a home care service that has massive problems with recruitment and retention. It seems to me that the Government's answer to all the issues—which are impacting on people right now—is to say that it is setting up a national care service. That is umpteen years away, but we have major issues now, and older people in Scotland are being let down badly. How can we start to get on top of the issues that are impacting on people right now, rather than simply saying that a national care service will magically fix all that in two or three years' time? It will not.

John Swinney: First, that is not what the Government says—I dispute that very firmly. Mr Rowley's extensive local authority and parliamentary experience mean he is very familiar with the journey of social care that has been undertaken during—if I am being charitable about those questions—the past 20 years. In that time, a number of developments have been undertaken to try to address the fundamental issues that Mr Rowley has raised. Those developments have focused on the aspiration to create person-centred care to avoid a situation in which people see any fragmentation in the delivery of care between what one experiences in the national health service and outwith it, if I can make that distinction.

Various developments have been undertaken, such as integration joint boards and health and social care partnerships— a variety of different mechanisms have been tried—to try to erode the barriers that exist in the system so that individuals have a much smoother journey and assessments are undertaken in a transferable way. Mr Rowley and I have been around long enough to remember when assessments undertaken by local authorities were not recognised by health boards. Over time, we have overcome things like that, but that absurdity used to exist in Scotland.

I see the national care service as a continuation of the efforts to try to deliver person-centred care. I accept Mr Rowley's point; I do not think that all the arrangements today are perfect. That is why the Government argues the necessity of the national care service.

11:00

However, some practical and tangible issues are making the delivery of social care challenging. One of those issues is the size of our working-age population. Mr Rowley and I have been around long enough to remember the population projections that came out about 20 or so years ago suggesting that the Scottish population would fall below 5 million and that it would be particularly weakened by the erosion of the working-age population. Thankfully—in my view—European Union expansion and our access to freedom of movement boosted our working-age population as a result of individuals migrating here. Indeed, they boosted our population in general, because they had relationships, had children and stayed here for a long time.

I have lots of these folk in my constituency; they are very welcome and I am delighted that they are there. However, many of them worked in our care sector, and, unfortunately, we are seeing quite a number of them leaving us as a consequence of Brexit. Our working-age population has been diminished and we have shortages in it in countless sectors, of which social care is one.

The Government is trying to address that in the short term by increasing remuneration in the social care sector and by trying to make it more attractive as a career. We are taking a number of steps to try to expand the workforce, because there are two issues that lie at the heart of the challenges that we are facing. The first is the availability of personnel to deliver social care. The second is the issue of quality that Mr Rowley has raised and which, of course, the Care Inspectorate addresses and, in some cases, intervenes directly on by placing requirements on care homes to improve performance.

A lot is being done in the short term to try to address those questions, but our overall efforts will be assisted by the way in which we develop the national care service to provide person-centred care for everyone in Scotland who requires it.

Alex Rowley: I would come back on that by saying to you that, in the medium term, Scotland could and should have its own immigration policy to tackle some of those issues—there is not a lot of disagreement there.

However, I am old enough to remember the Griffiths report that came out under Margaret Thatcher, which was the starting point for community care. Indeed, I remember writing an essay on that report and concluding at the time that, although the proposal sounded wonderful, it could not be about providing care on the cheap.

The reality is that we have seen a move away from the majority of home care in Scotland being delivered in-house by the public service and through local authorities to a shift into private provision. Indeed, in many authorities—including Fife, where I come from—the split is, I think, less than 40 per cent in-house delivery and more than 60 per cent external delivery. That has happened only because it is cheaper for councils to put that work out, and it is cheaper only because those staff are paid more poorly and their terms and conditions are horrendous compared with those in the public sector. That, for me, is the major factor in the current recruitment and retention crisis, but every time that I raise the matter with Government, the answer that I always get is about a national care service that is coming at some point two or three years down the road.

I do not believe that we have two or three years. If we do not tackle the issue now, it will just get worse, and older people up and down Scotland will pay the price. Will you agree at least to look at the issue of terms and conditions, and to start to put in place a timetable for addressing the issues that need to be addressed now?

John Swinney: I understand the issues that Mr Rowley is raising, but I have to point out that the Government has been taking a number of steps to significantly increase remuneration in the social care sector. We have done that in a number of stages, and social care remuneration is now much higher than the level that we inherited. We are making sustained improvements in that regard.

However, we also have to deal with the financial circumstances that we currently face. I said in response to the convener that a great many of the financial decisions that we take are framed by the political context in which we must operate and the fact that our budget is significantly affected by the UK Government's decisions on public expenditure. I think that Mr Rowley and I could probably agree that the profile of that is not great; we would like to see higher levels of public expenditure.

Within a tight financial context, we have been boosting social care remuneration. We are not talking about taking action at some point in the future—we are doing that now and have been doing that for the past few years. However, the inescapable problem is that we are still short of people. Mr Rowley has said that he thinks that, at some point in the medium term, Scotland should have distinctive immigration powers but, as we have been saying for a considerable time, we face such challenges in the here and now because of the UK Government's decisions, which have been dramatically damaging to Scotland's interests.

We have historically low levels of unemployment in Scotland today. A number of measures are in place, whereby we are trying to expand the workforce by supporting more people who are economically inactive to move into the workforce. Social care is a particular target. With the right support in place, we can mobilise and motivate people in all parts of the country to join the workforce. Whether by taking action on employability, on remuneration for social care staff or on the longer-term developments on integration, we are trying to strengthen the provision that is available for older people and vulnerable individuals, but we must deal with the political realities of the significant constraints that have been placed on us by the UK Government's decision making.

Alex Rowley: Just quickly—

The Convener: I am sorry, Mr Rowley, but we are running out of time, and two members have still to ask questions.

John Mason (Glasgow Shettleston) (SNP): I would like to make a comment. Mr Rowley almost seemed to suggest that quite a lot of care homes are not fit for purpose. I have worked in the sector and my mother was in a care home that is run by the third sector. We had excellent care. The Care Inspectorate gave the home a poor mark, but our family strongly disagreed with that and complained to the Care Inspectorate.

To go back to the issue of boosters, how is the programme for people to get their second booster going at the moment? Where will that programme go in the future? Will the boosters be extended to the whole population, or will we wait until next winter? What is happening with that?

John Swinney: The booster programme is going well. I am just getting the precise data in front of me. Among care home residents, 65 per cent have had booster jags. As of 26 April, among older adults in care homes, the figure is 69 per cent. The rate among the population who are aged 75 and over is 59 per cent. In total, 329,942 doses of the booster have been delivered. That comes on top of 4.4 million people receiving dose 1, 4.1 million receiving dose 2 and 3.4 million receiving dose 3. The programme continues apace.

Obviously, we are waiting for advice from the Joint Committee on Vaccination and Immunisation to inform any further steps that we take, but the existing programme is going well among the target population.

John Mason: So, there are no definite plans to extend the booster programme to the younger age groups.

Professor Leitch: There are not. There has been clinical advice and an indication that it probably will be extended in that way, but that might not happen until the autumn. Nobody knows for sure.

As members know, we are on the downward slope of the omicron wave, so the JCVI will have to choose what to do and when to do it. We have discussed that in the committee previously. The timing is quite important, because we do not want vaccine fatigue or people to think that they are going for a new vaccine every three weeks. We need to get the timing right for what will probably be a winter wave of the virus. We might have to face a wave between now and then, but there will almost certainly be a winter wave of some description. The world does not know yet what that will look like and which variant will be involved, but we would anticipate going down through the ages and the vulnerabilities in the autumn. We do not know whether the JCVI will say that the whole population should be involved again. If I were gambling on it, I would think that we would go down to the over-50s sometime in the autumn, around the flu vaccination season.

John Mason: That is helpful. Thank you.

I move on to long Covid—or post-Covid syndrome, if that is a better term. We were going to have a debate on that—I think that we will have one in due course. Can you say anything about the Government's thinking on that? One of the arguments seems to be about whether we should have specific long Covid clinics—I am not clear whether that means that they should be in a separate building—or whether we should basically feed people into the system, depending on whether the problem is respiratory, sleep-related or whatever.

John Swinney: Some of that territory was aired in oral questions yesterday. I will invite Professor Leitch to comment on that because it gets into clinical territory, but the approach that we are taking is that every patient who presents with a healthcare issue should be able to receive the support that they require. That is the founding principle of the national health service. As Mr Mason has just highlighted, individuals will present with post-Covid infection symptoms in different fashions. For some people, it will affect their sleep; for some, it will affect their energy; and for others, there will be respiratory issues. There will be a variety of different issues.

The founding principles of the national health service say that those individuals should be put on a pathway that addresses their circumstances. For example, if I had a respiratory problem, I would want to see a respiratory specialist so that it could be addressed to the best of their ability. That involves signposting individuals through the national health service to get the clinical intervention that they require.

We are exploring whether there are better ways to do that. All the research projects are looking at whether there are better ways to try to create those pathways as opposed to taking the approach that our health service is founded on, which is, essentially, that we all go into the health service at a general level, some people stay out there, and others go into greater specialisms where that is required. That is the approach that has been taken, but we are exploring whether that is the most effective way of dealing with a set of conditions that have emerged and become significant in the past two years or so in our society.

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

Professor Leitch: You have summarised things relatively well. Post-Covid syndrome is a better description, because it illustrates the broad nature of the conditions. We do not know enough about it. We do not know how long it lasts, how many people are at risk, or which groups are at risk. We have more knowledge of that than we had a year ago and certainly more knowledge of it than we had two years ago.

Some countries in the world have health services that do not look like ours. The pyramid is twisted the other way so that, if a person has hip pain, they can see the elite orthopaedic surgeon tomorrow. However, that might not be the person whom they needed to see with their hip pain; the person whom they needed to see would probably be a generalist, who would send them to a physiotherapist, and they might never need to see the elite orthopaedic surgeon, who costs most and is the busiest.

Post-Covid syndrome is no different. We want to filter the vast majority of those cases with general advice, which might be from NHS Inform, NHS 24, general practice, physiotherapy or respiratory therapy. People should move through the system quickly and efficiently. I think that the worry for people is that we are somehow trying to put them off getting to the people who can help them. That is not the intention; the intention is to get people the right care in the right place at the right time. Eventually, the person might need a neurologist.

However, 10,000 people do not need a neurologist. It might be that a tiny proportion of them need a neurologist and a respiratory specialist.

There is nothing to stop health boards putting a sign on the wall and saying, “This is the long Covid clinic”. If the clinicians in Forth Valley or Orkney thought that that was the right thing to do, that is exactly what they would do.

11:15

Just now, globally, it appears that the best thing to do is to see patients in a generalist area—medicine, general practice or some kind of therapy—and then move them through the system as quickly and efficiently as possible. That makes a lot of sense to me. The long Covid clinic thing has become a bit of a hot button and is perhaps a distraction from the broad care that we must offer to the long Covid population, who are suffering from a disease that we do not understand enough about.

John Mason: I take the point that we are still learning and do not fully understand it. If somebody has only one symptom, it absolutely makes sense that they go to a respiratory specialist or whoever it might be. However, the concern that I am picking up is that, if people have three or four symptoms, they might have to go to three or four hospitals or specialists. Would it be possible for them to go to a one-stop shop?

John Swinney: That would require us to configure the national health service around the circumstances of a few—I do not know how many; perhaps 1,000 or 10,000—individual patients, as opposed to trying to ensure that every patient gets the treatment that they require.

We have circumstances just now in which, unfortunately, individuals with complex healthcare needs have to have a range of different specialist interventions to meet their needs. I can only give a personal observation on this: I do not have healthcare issues, thankfully, but if I did, I would want to see a person who knows what they are doing. With all the greatest respect to Professor Leitch, I am not going to consult him on, say, open heart surgery.

Professor Leitch: Or dentistry, frankly.

John Swinney: Or dentistry.

Professor Leitch: You definitely should not do that.

John Swinney: That approach is the key thing that most patients are interested in.

John Mason: That is fine. I have one final question. Talking of dentistry, has there been any change or improvement on that? I know that there is a new payment system to encourage dentists to see more patients. Is that happening or is it too early to tell?

John Swinney: Two factors have been a challenge in relation to dentistry. It has been a high-risk area of activity during Covid, and we have had to reduce the capacity of the system as a consequence on that. We have put in place financial mechanisms to ensure that the profession is supported to do as much as possible, and that is gradually rising as the situation improves. Given that we are now in a less challenging position in relation to the prevalence of the virus, that enables more to be done.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Good morning. I want to briefly go back to John Mason’s point about long Covid clinics. We have heard a lot of debate and challenge in the chamber about the Scottish Government not doing enough to set up long Covid clinics despite them existing in England. What are they doing in England that is so much better than what we are doing in Scotland and which means that there is now so much demand for long Covid clinics?

John Swinney: I am not sure that I can subscribe to the argument that there is evidence of something better being done in England. I can subscribe to the argument that something different is being done with the establishment of long Covid clinics. However, I come back to the answer that I just gave Mr Mason, which is that our health service is founded on the principle that patients should get the treatment that they require and see the people who they need to see to ensure that interventions are appropriate. That founding principle must be honoured, and we must constantly explore whether there is a more effective approach that we could take. That is what the research projects that we have commissioned are all about.

Jim Fairlie: On a number of occasions in the chamber, Sandesh Gulhane has cited a particular system that a particular hospital in England is using. Have you looked at that?

John Swinney: Research work is under way to look at different models and approaches. If there is learning to be gained from examples in other parts of the United Kingdom and across the world, we will be open to that. Our health service is constantly engaged with other health systems to identify the most appropriate interventions to support individuals.

Jim Fairlie: You are not working in isolation.

John Swinney: Not in the slightest.

Jim Fairlie: Alex Rowley talked about the conditions for staff in care homes. As you had that

conversation, a question popped into my head. Let us assume that the Scottish Government said, "Do you know what? We're going to play a blinder and pay care home staff £15 an hour so that they are very well remunerated." Where would the staff come from? Would we have to track down new staff?

John Swinney: As I said in my answer to Mr Rowley, we have historically low levels of unemployment just now. Unemployment in Scotland is at a very low level—lower than the level in the rest of the United Kingdom.

However, we have a slightly larger economically inactive population. The Government is trying to expand our working-age population by working with people who are currently economically inactive to try to find the means to make them economically active. We are trying to do that through a variety of interventions relating to employability, skills, the provision of early learning and childcare, and the meeting of transportation costs. We are also trying to address wellbeing issues that might undermine an individual's ability to enter the labour market. Pilot projects are being undertaken with individual cohorts in the cities of Dundee and Glasgow to explore how we learn lessons and expand our working-age population.

Mr Fairlie is right; we have to motivate more people to enter the labour market. Otherwise, people will simply move from one sector to another, which will create shortages and other issues in other sectors of the economy.

The two fundamental issues at the heart of the question are the size of the working-age population and the relative attractiveness of social care employment. The Government is trying to expand that population.

Jim Fairlie: That is the point that I am trying to make. Please do not think for one second that I am saying that people should not be very well paid for the jobs that they do. However, a local business in my constituency said that, if it bumps up wages in order to bring in as many people as it can, it will be robbing Peter to pay Paul. Another sector will lose staff if we do not have enough people working here.

We have heard that staff in the test and protect system are being made redundant or being redeployed. What is the current position? Are staff available from that system to go into other sectors?

John Swinney: There is a fine line to be walked. We want to retain as much of the really good strength and capabilities that have been built up in the testing infrastructure, but if we move away from that scale of testing infrastructure in the country, some people will undoubtedly become available for employment. We have to work with individuals to ensure that they are appropriately trained and skilled to remain in the labour market, albeit that they might be undertaking different tasks. The Government's economic objectives are about maximising economic participation by those who are able to participate, hence the pilot projects that we are undertaking to tackle the levels of economic inactivity in Scotland. We want to reduce those levels and expand the size of the working-age population.

Jim Fairlie: Where are we in relation to the state of the pandemic? What is the situation with transmission, hospital admissions, intensive care unit admissions and so on?

John Swinney: Based on the best measures that we have for the prevalence of the virus, we are in an improving position, with one in 19 of the population having the virus. I think further data on that will come from the ONS survey tomorrow.

Professor Leitch: Yes, tomorrow.

John Swinney: That number has moved from being one in 11 people at its most acute, which is a significant relaxation. Waste water sampling is showing a decline in the prevalence of the virus.

The number of patients in hospital with Covid is now sitting at about 1,500.

Professor Leitch: That is good: it is 1,529.

John Swinney: There we are. The number of patients in ICU is—

Professor Leitch: Twenty-five.

John Swinney: I was going to say 26. We are just about there.

To have 1,500 patients in hospital with Covid is still quite a sizeable number, but a great deal better than when it was in excess of 2,400, which is where we were just a few weeks ago. We are seeing the number steadily coming down, which marks the decline in the prevalence of the omicron variant.

Professor Leitch: Let me give you one piece of context. I looked yesterday at the comparison between current data and the data from April 2020, exactly two years ago. We now have 25 people in intensive care; we had 220 in intensive care about three weeks after the start of lockdown. We have 1,529 people in hospital with Covid; we had 1,520 in April 2020.

That illustrates that the pressure is not over. It has moved significantly and the harm has been significantly reduced because people are not in intensive care and not progressing to death, but we still have quite a lot of people with a positive diagnosis. We should remember that some of them are not in hospital principally because of

Covid; some of them are in with a positive Covid test after having a stroke or something else.

Looking at all the health boards illustrated to me that the pressure—particularly from the volume of cases—is still very real. Intensive care feels almost back to pre-pandemic normality; but the wards do not.

Jim Fairlie: That indicates that the vaccine is doing its job.

Professor Leitch: That is exactly right.

John Swinney: That is absolutely the issue.

The Convener: I am sorry; we do not have time for any more questions. That concludes our consideration of this agenda item. I thank the Deputy First Minister and his officials for their evidence.

As we move away from having ministerial statements on Covid-19, I especially thank the Deputy First Minister, Professor Jason Leitch, Elizabeth Blair and all the officials who have attended the committee in the past 11 months. We really appreciated you making yourselves so available to respond to our questions.

Agenda item 4 is consideration of the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No 6) Regulations 2022. Deputy First Minister, would you like to make any further remarks about the instrument before we take the motion?

John Swinney: I will make a brief statement to place on record the detail of the regulations.

The regulations before the committee today were made to implement the first phase of lifting the face covering requirements at the beginning of April.

The regulations do three things. First, they remove the requirement for a person who enters or remains indoors within a place of worship to wear a face covering. Secondly, they remove requirements to wear face coverings at marriage ceremonies, civil partnership registrations, funerals and commemorative events related to the end of a person's life. Finally, the regulations also remove a number of the exemptions from the requirement to wear a face covering that applied in places of worship or at the events I mentioned, because those are no longer required.

By the end of March, the latest wave of coronavirus infection had peaked, or was by then peaking. The Government was therefore able to announce a phased removal of the face covering requirements, with the first phase being put into effect by these regulations. Subsequently, we were able to confirm that the wider requirement for face coverings would be converted to guidance on 18 April.

Motion moved,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (Requirements) (Scotland) Amendment (No. 6) Regulations 2022 (SSI 2022/123) be approved.—[*John Swinney*]

Motion agreed to.

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

That concludes our consideration of the agenda item and our time with the Deputy First Minister. I thank him and his officials for their attendance. That concludes the public part of the meeting.

11:30

Meeting continued in private until 11:32.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba