OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 9 March 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 9 March 2021

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HEALTH AND SPORT COMMITTEE

9th Meeting 2021, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Minister for Drugs Policy)
Michael Matheson (Cabinet Secretary for Transport, Infrastructure and Connectivity)
Liam McArthur (Orkney Islands) (LD)
Craig Thomson (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 9 March 2021

[The Convener opened the meeting at 10:00]

Interests

The Convener (Lewis Macdonald): Good morning, and welcome to the ninth meeting in 2021 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton; I welcome Liam McArthur, who is attending in his place. In accordance with section 3 of the code of conduct for MSPs, I invite Mr McArthur to declare any interests that are relevant to the committee's remit.

Liam McArthur (Orkney Islands) (LD): Thank you, convener. It is a pleasure to be with the committee today. I am not aware that I have any declarable interests, but I refer members to my entry in the members' register of interests.

The Convener: Thank you. I remind all members and witnesses to ensure that all mobile phones are on silent and all other notifications are turned off during the meeting.

Drugs Policy

10:01

The Convener: The next item on our agenda is an evidence session with the Minister for Drugs Policy, Angela Constance, on the Scottish Government's updated plans and proposals for drugs policy in Scotland. I welcome the minister, who is accompanied by Morris Fraser and Michael Crook, both of whom are members of the Scottish Government's drug deaths team. I thank you all for joining us today, and I invite the minister to make a brief opening statement.

The Minister for Drugs Policy (Angela Constance): Thank you, convener, and good morning to you all. I am grateful for the opportunity to speak to the committee.

Following the publication of the 2019 statistics on drug-related deaths in Scotland, the First Minister announced the need for the Scottish Government to lead a national mission to save lives and improve lives. In her statement to Parliament on 20 January, she pledged an additional £50 million in each of the next five years to drive forward the changes that we need.

Our mission is to get more people into treatment, as we know that that is a protective factor that keeps people safe. That is one of my immediate priorities. In order to do that, we need to improve our treatment offer and make it much more accessible to those who have the greatest needs.

A significant amount of work, including work by the drug deaths task force, is already under way to increase treatment numbers. The roll-out of the new medication-assisted treatment standards that the task force has developed will ensure that a range of treatment options are available to anyone who needs them, no matter where in the country they are, on the day that they request them. That also includes my commitment to increase the capacity of residential rehabilitation. I have committed to a significant uplift in the current provision of residential placements, and I have asked a residential rehabilitation working group to examine how we can do that quickly.

In addition, I am working on other improvements, such as expanding the reach of examples of good practice—for instance, the heroin-assisted treatment service, which is currently available in Glasgow but could be replicated elsewhere. We are also working to make long-acting buprenorphine more available as an option for those who would find it more suitable than methadone or other opioid substitutes. Those moves will help to ensure that treatments will be

more widely available, which will mean that all areas will offer a more person-centred approach.

We are working with stakeholders to gear up the way in which we take account of those with lived and living experience, in order to ensure that our services, initiatives, plans and policies are informed by the views and experiences of people who have gone through treatment or who are in recovery and those of their families, as well as those of people who are not currently in treatment.

In order to step up our efforts to face those challenges, I will convene an implementation group, in which I and other Scottish Government ministers will work alongside chief officer or director representatives from health and social care partnerships, integration authorities and other organisations, such as the royal colleges, to ensure that we align our strategies and to support better delivery. In essence, that will allow us to ensure that our public health emergency response—our work to save lives—is far better embedded in our wider work to improve lives, whether it involves mental health, housing, adverse childhood experiences, education, prevention or poverty and inequality. The implementation group will draw on advice not only from the drug deaths task force, but from the new residential rehabilitation working group, as well as from organisations that represent those with lived and living experience and their families.

In all that we do, partnership working will be key. Since I came into post, one of my first priorities has been to meet as many organisations and individuals working in the field as I can. That has allowed me to hear a wide range of thoughts and opinions about how we can make improvements, reduce deaths and improve the lives of individuals and their families.

In my role as minister, it is my responsibility to build relationships and work positively with all those groups. In addition, I am clear about my responsibility to work with Parliament and parliamentary committees in order to ensure that, as we move forward, we can build more of a consensus across Parliament on the direction of travel. I hope that my time with the committee this morning is an opportunity to start to build that consensus.

I welcome the opportunity to answer any questions that members have.

The Convener: Thank you, minister.

As you have described, you have a broad remit, and there is no doubt that a lot of your work will involve partnership building along with other aspects. Inevitably, however, there is a sharp focus on the rate of drug deaths. National Records of Scotland has reported that the rate in Scotland is 3.5 times that of the United Kingdom as a whole and higher than anywhere in the European Union.

Before I ask my first question, I say to your officials that, if they wish to come in at any point to supplement your answer, they should type R in the chat box in the usual way. Members will know the routines to follow. Our questions will, I hope, cover the whole range of your responsibilities.

What focused action to reduce drug deaths in the coming year do you envisage coming out of the processes that you have described, minister?

Angela Constance: That is an important question, because we need a sharp focus on that aspect, and on leadership, resources and implementation. The purpose of declaring a national mission to address what is, to be frank, a national disgrace is, in essence, to get more people into treatment, because we know that the right treatment for the right person at the right time provides a protective factor.

As part of the national mission, there are five priority areas. The first is fast and appropriate access to treatment; all the evidence shows that people need to find ways into treatment much more quickly and effectively. Secondly, we have listened to the voices in Parliament and the lived and living experience community, and we are therefore focusing on residential rehabilitation. Thirdly, all our endeavours, both within and outwith Government, need to be far more joined up, particularly in respect of community services. Fourthly, there is a clear role for front-line organisations, especially those in the third sector. Lastly, we need to overcome the barriers around introducing overdose prevention facilities while focusing on what we can do now. Thus far, the heroin-assisted treatment work in Glasgow has been very successful, although it is in the early stages, and we need to look at what more we can do elsewhere in Scotland.

We are very much focusing on what we can do as quickly as we can. We need to ensure that, in our endeavours on both harm reduction and recovery, we are all pulling together in one direction.

Our focused work on saving lives, which you touched on, convener, needs to be embedded in our bigger, broader work on improving people's lives. That is where the cross-Government endeavour must really kick in.

The Convener: Absolutely. In summary, would it be fair to say that your top priority is access to treatment?

Angela Constance: Yes. The five priorities that I have outlined all feed into our focus on getting more people into treatment.

The Convener: It is clear from the National Records of Scotland statistics that rates of drug deaths are very high in some areas. The city of Dundee in particular is affected, as are places such as Glasgow and Inverclyde. Those are often areas of high social disadvantage. Would it be reasonable to expect that interventions will focus on areas that have higher rates of drug deaths, such as Dundee and Glasgow?

Angela Constance: Yes. To put that in context, I will make two points.

You are absolutely right to highlight that the areas with the highest rates of drug deaths also have the highest rates of deprivation. We need to focus our attention on where the problem is most acute. To help with that, some of the initial emergency funding that we released—in particular, the £3 million for alcohol and drug partnerships—was allocated by taking into account the proportions of drug deaths in particular local authority areas.

However, it is important to note that it is a national mission and that we cannot leave any area of Scotland behind. I am conscious of the needs of rural Scotland and that some of the issues and difficulties in rural Scotland—in particular, service delivery—can be quite different. In addition, we always need to give special consideration to, and provide flexibility for, our island communities.

We absolutely need to target resources to the areas and the people with the greatest needs, and that points us to specific areas of the country. Nonetheless, we must do that in a fashion in which we leave no part of the country behind, because it is, after all, a national mission.

The Convener: Before I call Emma Harper, Sandra White has a brief supplementary question.

Sandra White (Glasgow Kelvin) (SNP): First, I note that men represent 69 per cent of drug deaths in Scotland, which is very worrying. Secondly, prescription drugs are a huge issue in Glasgow and other areas. Have you looked at targeting males and at the issues around prescription drugs?

Angela Constance: With regard to the gender balance, Ms White is correct to say that, in talking about drug deaths, we are talking mostly about men—or men over the age of 35. There are always particular challenges in ensuring that men can access services. We know that, with regard to health as a whole, men can sometimes be reluctant to go to their general practitioner for more physical ailments.

There are specific issues around the needs of men, and of—dare I say it?—men of a particular age. In talking about drug-related deaths, we are often talking about people who have a substantial history—perhaps 20 or 30 years—of drug use. The heroin-assisted treatment project in Glasgow is having some success, in particular in working with people who have extraordinarily lengthy histories of drug use.

Nevertheless, we cannot and must not ignore the fact that the number of women who are dying is increasing. Over the past two years, we have also seen an increase in the number of people under 25 who are dying and a significant increase in drug-related hospital admissions. Although those groups have much in common, we need to pay attention to the needs of men while also addressing the needs of women and younger people.

10:15

With regard to prescription drugs, there is an issue in Glasgow and elsewhere with benzodiazepines, which are often used with other substances—in particular opioids. We see illicit benzodiazepines, as opposed to prescription medication, as much more of an issue. That is related to issues around the production of street valium. Police Scotland has told me that someone can, within hours, using a pill press, make half a million tablets and sell them for pennies. The people who produce those substances illegally have found ways to package them in blister packs and cardboard boxes so that they look pretty authentic, when, in fact, they are not. In addition to addressing issues around how we regulate pill presses and deal with illicit benzodiazepine production and use, we need to find alternative, and better, ways to treat benzodiazepine dependency.

Emma Harper (South Scotland) (SNP): Good morning. In her statement, the First Minister talked about investing in more public health surveillance so that we will be able, rather than waiting for annual statistics, to look at more focused or targeted information—for example, regarding the street benzodiazepines that you just mentioned. What plans are there to introduce more regular reporting on drug deaths in order to ensure that responsive and proactive action, such as more direct data management, can be taken?

Angela Constance: There are two aspects to that. National Records of Scotland is responsible for collecting and publishing data on drug-related deaths, but as Ms Harper pointed out, those data come out annually, and I am keen to find ways of reporting much more regularly on drug-related deaths. Work is already under way on that with Public Health Scotland, NRS and Police Scotland, and with Scottish Government officials in respect of in-house analysis. There is a compelling case

for moving to more regular reporting, and I want to do so.

I have held other portfolios in Government in which relevant statistics have been published. I am thinking back to my days in charge of the youth employment portfolio, and other portfolios, in which data were released monthly, quarterly or biannually. We need to move to more regular reporting, as that is an important piece of the jigsaw.

In addition, as a result of the pandemic, Public Health Scotland's public health surveillance work has improved. As we begin to look to life beyond the pandemic, I want us not to roll back on that progress, but to build on it, so that we have better data and information that are nearer to real time. That will mean that Government and services in the community can be fleet of foot in responding to the needs of some of the most marginalised people in our society.

Emma Harper: Our committee papers highlight that there has been some delay in the implementation of the Scottish Government's drug and alcohol information system—DAISy—database. I assume that that delay is related to the pandemic, which we have been dealing with as a priority. How can DAISy be used to inform policy development? What impact has the delay in its implementation had?

Angela Constance: DAISy is a Public Health Scotland tool. Emma Harper is correct to say that historical issues have affected its implementation, but my understanding is that those have been to do with the early pilots that some health boards undertook, rather than with issues arising from the pandemic.

DAISy has now gone live in four areas, as a precursor to the full system coming on stream on 1 April. Essentially, the system's purpose is to enable us to get better data so that we understand better the impact of alcohol and drug treatment services with regard to who is accessing which services and what the outcomes are. Given that my focus, and the focus across our entire system, must now be on improving delivery and helping us to reach those who are most at risk or are hard to reach, that work is important.

However, it is important to highlight that the system builds on the existing data that are held by Public Health Scotland. It has two databases: one for drug and alcohol waiting times and one that contains more granular information about drug misuse. Much of the information is already available; my understanding is that DAISy will ensure that it is joined up and available in one place so that it can be accessed more quickly and used to better effect.

Emma Harper: You mentioned that the system is being piloted in four areas. Those include Ayrshire and Arran and Dumfries and Galloway, which is interesting to me, as those are in my South Scotland region. The other areas are Grampian and the Western Isles. Has any information been received on how that is working so far?

Angela Constance: I have not been alerted to any difficulties so far. There is a very short lead-in phase, from the end of last year to April this year, so those areas were selected because they have smaller populations. As with much in technology, it is good to start small and see how things go, but the full roll-out is on course for April this year.

Emma Harper: Good. That was an answer to my final question. I was going to ask when we expect the roll-out to be complete, and you have just informed us that it will be done by April 2021.

Brian Whittle (South Scotland) (Con): Good morning. In a recent blog post, the Scottish Drugs Forum indicated that some

"57,000 people have a drug problem involving opiates and/or benzodiazepines",

which is

"one in … 80 adults".

Several members of this committee have been involved with the work of the Scottish Affairs Committee, whose report, "Problem drug use in Scotland", concluded:

"Addressing the root causes of problem drug use requires radical, whole-system change, rather than piecemeal reform."

In a ministerial statement on drugs policy, the First Minister focused on five key areas that we need to address urgently. How are those five key areas decided on, and how will they be prioritised? I am interested specifically in how that resource will be allocated. You said that the alcohol and drug partnerships will be the gatekeepers for that money. My concern is that some third sector organisations might lose out on that resource.

Angela Constance: I appreciate that question from Mr Whittle. He is absolutely right that we need to take a whole-system approach to the issues. The Government has some experience in this area—for example, through the work that was done in and around improvement sites in our health service, on safety and on reducing youth offending. We need a similar whole-system approach to driving down drug-related deaths.

On the question of how we selected those five areas of focus, our focus—as I said in response to the convener—is very much on getting more people into treatment that is right for them, and which enables them to access other services and

support that get under the skin in order to look at the root causes of their addiction.

The prioritisation of the five areas—fast access to treatment, residential rehab, much more joined-up services, front-line services, including in the third sector, and the work around overdose prevention facilities and heroin-assisted treatment—is based on international evidence, of which Mr Whittle and his committee colleagues will be well aware, having participated in the work of the Scottish Affairs Committee, and on what we know from evidence in Scotland and elsewhere in the UK.

When I think of evidence, I think about clinical advice and research and evidence that academics have gathered over a number of years. However, what is particularly important to me, given my background in dealing with the communities and social security portfolios, is the voice of lived and living experience, and what people tell us about what is, and what is not, working on the ground.

I reassure Mr Whittle that I take very seriously the role of the third sector. From all my experience in Government—this is my seventh ministerial portfolio—and my experiences as a front-line social worker, I know that the third sector can reach people whom statutory services cannot reach. As we have seen during the pandemic, the third sector can react quickly and flexibly, and it is often the place where innovation can be led from the front.

I absolutely want to ensure that we fund alcohol and drug partnerships, and I will follow the money to ensure that the additional Government resource that is allocated to those partnerships gets to them and that they, as commissioning bodies, have good partnerships with local third sector and grass-roots organisations. However, I will also fund such organisations directly, and we have started to do that. Of the £5 million in emergency funding, £3 million went to alcohol and drug partnerships, and we set up two funds: an improvement fund to which organisations can apply directly for bigger sums of money, and a grass-roots fund.

As we move forward, I will lay out our approach and plans in respect of funding alcohol and drug partnerships, and our plans for the longer term in and around funding grass-roots and third sector organisations.

Brian Whittle: I am pleased to hear the minister discuss the importance of the third sector. I agree with her 100 per cent that the sector can sometimes have a reach that statutory services do not have, and that it can be a route, or a stepping stone, into those statutory services. It is crucial that we ensure that third sector organisations—although some of them could, constitutionally, be better than they are, they are nonetheless extremely effective—are involved in the process, and that we bring everything to bear to tackle the issues.

What analytical work will you undertake to ensure that that work is supported and that the finances and the resource get to where you want them to be?

Angela Constance: With regard to financing third sector and smaller organisations, the early feedback that I have had from a range of organisations suggests that we have to look even more closely at how we can enable organisations to access funds. We also need to look at what support we can give organisations on the ground to facilitate the work of the internal structures within those organisations that are required to access funds. Our announcement of the £1 million grass-roots fund is not the end of the story in how we improve access or increase funding as we move forward.

10:30

The analytical work is very important, and Public Health Scotland is developing an extensive programme of research, evaluation and monitoring. We need that close surveillance and detailed analytical work to inform our national mission—in a way, I am stating the obvious there.

The task force is also investing in research work, but Public Health Scotland's role is especially important because it already has a responsibility to monitor and evaluate the "Rights, respect and recovery: alcohol and drug treatment strategy". It does that through the monitoring and evaluating Scotland's alcohol strategy, or MESAS, programme. We need to ensure that that work evolves into something that can better evaluate our national mission.

I will be interested, in particular, in how we monitor and evaluate the implementation of the medication-assisted treatment standards, which are about the principles and good practice behind the delivery of such treatments, and how we link them with other treatments that get under the skin to address the root causes of addiction.

Brian Whittle: How is the Government taking a cross-departmental approach to ensure that there is a more joined-up approach to delivering services? Much of the discussion right now seems to be about how we deal with people who have fallen into addiction, but the other side of the coin is how we create an environment in which people avoid falling into addiction in the first place. That involves thinking about community assets, and opportunities for people to engage in activities in the community. Treatment for mental health issues is another hugely important aspect in dealing with

addiction. How is the Government working to deliver across portfolios to address the whole gamut of issues?

Angela Constance: Mr Whittle is absolutely right to say that we need excellent cross-Government and cross-portfolio working. That is where the implementation group, which I will chair, will come into its own. I have spent a lot of time engaging pretty deeply with other ministers across various portfolios in advance of establishing that group. The implementation group, and the work that we do to evaluate the work that it oversees, will be really important.

I will give some practical examples. We know that at least half of those who have an issue with problematic drug use also have mental health problems, and that 23 per cent of those who have been lost to drug-related death had recently engaged with mental health services. The Minister for Mental Health, Clare Haughey, and I have already started some joint portfolio work. Our work on drug policy will need to be joined at the hip with our work on mental health policy. There is work under way in the mental health portfolio in relation to the pathfinder project in Tayside, which is about embedding mental health and addiction services together.

Hospital admissions are a key area in which the task force has done a lot of work. We know that the number of admissions to hospital, whether to accident and emergency or to psychiatric services, as a result of drug-related harms is increasing. When people present at hospital, therefore, we need to ensure that they are immediately plugged into services. Again, that is where the third sector comes into its own. Members will probably be aware of the work of Medics Against Violence and its peer navigator initiative. Work on peer navigators is starting to be rolled out to ensure that people are plugged into community services to enable their drug and mental health issues to be addressed. That is particularly important. In addition, there is a whole body of work on unplanned discharges from care.

I also engage a lot with Kevin Stewart, the Minister for Local Government, Housing and Planning, on homelessness, as we know that people who have a drug problem make up half of homeless deaths. Our work in that regard is focused on outreach. With regard to prevention, there is a big role for schools. Another aspect is the work in the justice system on diverting people into treatment at every opportunity.

I am conscious that I have spoken at length, and members will have questions. Nevertheless, I make one final point: we should not forget the importance of our work around poverty and inequality in addressing these issues.

Brian Whittle: Sandra White touched on the issue of prescription drug dependence. The committee has done quite a bit of work on that, as has the Public Petitions Committee, which I sat on for a number of years. I think that we would probably conclude that there is an overdependence on such drugs, and a medicalisation of mental health issues in particular. What work can the Scottish Government do to reduce the prescription of mental health drugs, which seems to be a problem, and to introduce other treatments, which would inevitably reduce prescription drug dependence?

Angela Constance: First, I always give a little health warning when people speak very broadly about overdependence on mental health drugs. I am a former prison social worker and mental health officer, and I worked at the Carstairs state hospital for five years before I was elected to Parliament. There are people who have severe and enduring mental illness, and psychiatric illnesses such as schizophrenia, for whom medication plays a crucial and important role. We need to take a little care in how we articulate concerns, which can be legitimate, when we talk about medication. Over many years, when I was in the field, I was involved in work to encourage people to take medication in order to reduce the risk to themselves and to others.

That said, people should not be prescribed medication without having access to other treatments. People need choices and options for treatment, including medication. That is where the medication-assisted treatment standards are important. When you or I go to the doctor about any issue, we are treated like adults and given information, and we are enabled and empowered to make informed choices about our own health. We have to apply the same standards for people who are seeking assistance and treatment for drug issues.

I am conscious of the Public Petitions Committee's work on prescription medications. I think that the committee looked at five classes of medication, including prescribed benzodiazepines. As I said to Sandra White earlier, much of my work focuses on the illicit use of benzodiazepines, which is quite different but nonetheless links in with the work on reducing dependence on prescribed benzodiazepines.

The Cabinet Secretary for Health and Sport has looked at recommendations flowing from the short-life working group that was established as a result of the petition that the Public Petitions Committee discussed. A consultation will run from March to June; that work is being taken forward by the health secretary, but we will keep close tabs on it.

In parallel with that work, the drug deaths task force is looking at how we can better treat benzodiazepine dependence, with a particular focus on illicit benzodiazepine dependence. We should bear in mind that the statistics since 2009 show that there has been a 450 per cent increase in drug-related deaths in which benzodiazepines were implicated. That is very different from the situation elsewhere in the UK, where there has been an increase of 53 per cent over the same time period. Scotland has a particular issue with illicit benzodiazepines, which is different from the issues around prescribed benzodiazepines.

Sandra White: I have some questions on the residential rehabilitation working group's recommendations, which were published on 4 December. You mentioned residential places and on-going treatment. Are there timescales for meeting all the recommendations? I know that they are comprehensive. How will progress be evaluated and reported on?

Angela Constance: I intend to continue in the way that I have started, by publishing information on the progress that we are making. As Ms White intimated, the Government responded positively to the work of the short-life working group on residential rehab, and accepted each and every one of its recommendations. There is work to do on equitable access; better capacity planning; much clearer pathways into residential rehab; different models of delivery; and—crucially—how we implement all the recommendations. That work will progress at pace. I have set up the newly convened residential rehab working group. While that work continues, I have ensured that there is more money in the system, because there is currently capacity in the system to enable more people to go into residential rehab. In addition to our work on sorting out pathways and access, there is now money in the system to facilitate more access to residential rehab.

Sandra White: You mentioned pathways. We know that a good practice guide on pathways into and out of residential rehabilitation is currently being developed. You also mentioned some of the work that has been taking place, and the money that is there. Can you elaborate on that, and on the development of the good practice guide? Do you have a timescale for its publication?

Angela Constance: I do not have a specific timescale in mind for that, but I am happy to keep the committee informed. We will progress the work as fast as we can.

The new residential rehab group will need to do some pretty detailed work, looking in particular at issues around women, as there is a gap in residential rehab that is geared more towards the needs of women, especially those who have children. We want to do that work properly. However, as I intimated, there is £20 million available each and every year going forward to be invested in residential rehab. Many providers are operating under capacity, so there is already capacity in the system to be accessed.

With regard to the good practice guide, we want to do as much as we can, as fast as we can, to encourage alcohol and drug partnerships, and other bodies that have a role to play, to use that information to assist their work on the ground.

10:45

Various services are already available. I have met Alternatives West Dunbartonshire, and folk will be familiar with the Lothians and Edinburgh abstinence programme There is a lot of work to do in and around residential rehab, in particular to ensure that rehab care and treatment are properly connected with aftercare services. That is why, in the medium to longer term, we want to take a more regional approach. If people in every part of Scotland are to be able to access residential rehab, we need to ensure that we have the right configuration of services and treatment available in different parts of Scotland too.

Sandra White: I completely understand what you say about women in particular. In Glasgow, it is very difficult for women to continue a course of rehabilitation if they have children. There has to be a choice. As you say, there is a lot of unmet need in terms of aftercare. How would you evaluate the level of unmet need in that respect?

Angela Constance: Again, that is a fundamental part of the remit of the residential rehab working group, which will look at the best ways to evaluate the impact of residential rehab in Scotland and at how we can quickly increase capacity. I have already said that we want to use the capacity that is not being used, but we also want to increase capacity to ensure that we get the right level of service in the right places across the country.

David Stewart (Highlands and Islands) (Lab): Good morning, minister and officials. My questions relate to Covid-19. As the minister will be aware, the United States Centers for Disease Control and Prevention has suggested that the pandemic may have led to "an acceleration" in the number of overdose deaths. Has the Scottish Government carried out any research in that specific area?

Angela Constance: Public Health Scotland has been producing regular surveillance reports throughout the pandemic. I am conscious that there is much about the impact of the pandemic that we may not fully understand, and I am always concerned about the potential for blind spots.

We know that we need to continue to build on Public Health Scotland's improved surveillance work—we do not want to step back from that work as we look beyond the pandemic. I am conscious that, while services have done a lot to readapt their provision in the context of the pandemic, supply routes for illicit drugs remain active. In short, Public Health Scotland's work in providing those regular reports is very important.

However, the intelligence that we get from organisations on the ground is also important. From those organisations, we know much about innovative practice, and we know that people have managed to use the enforced time and space arising from the pandemic constructively to find different ways to reach people and enable them to access services. I am also aware of the mental health impacts arising from the pandemic and the associated isolation.

David Stewart: I flag up the joint research project by the University of Edinburgh and the University of Stirling on the effects of Covid on those who use drugs. I am sure that you and your officials are aware of that—I certainly endorse the reporting from the project, and it would be worth while for the Government to look at how it could affect policy making.

My next question is about decision making on Covid-19 restrictions. Were the needs of marginalised groups, such as those who use drugs, assessed and taken into account when restrictions were made?

Angela Constance: Yes—much of that work was done by my predecessor. It included messaging on when, and how, it would be safe for mutual aid support organisations, which are crucial to many people in the recovery community, to proceed with their work. The Government's engagement with stakeholders, on the basis of information that we received from national health service boards and others, has allowed us to work with services on how they can take a different approach to outreach.

I am aware from one organisation in the recovery community, in north-east Glasgow, which wrote to me recently, that it is continuing to support around 500 people. To be frank, that is remarkable. The service provides face-to-face contact only in certain circumstances, but it is doing much more work online, and it is also running a lot of chat-and-walk sessions. Around a month ago, I announced a significant investment in digital participation—it was a substantial investment of £2.75 million. Services have improved in many ways, not just as a result of how people have needed to reach them during the pandemic, but because people have been looking for those improvements for a long time.

We have rolled out the slow-release depot buprenorphine injection—Buvidal—as an alternative to methadone and other opioid substitute therapies. It takes people away from daily interaction with a pharmacist or with medical personnel in order to get their daily dose, and frees them up to get on with other aspects of their life, and it potentially frees up support services to work on the root causes of addiction. We have increased access to Buvidal in prisons and the challenge for us will be to ensure that that medication is more freely available to people in the community.

David Stewart: I come to my final question, which the minister partially touched on in her previous answer. What support have drug treatment and recovery services had to enable them to remobilise?

Angela Constance: It is to the significant credit of drug and alcohol services that they have remained open during the pandemic, although they have had to find different ways of working. As I mentioned, we will want to keep hold of some of the new ways of working, because they benefit people who receive those services, and they are indicative of better ways of working in general.

As part of the overall NHS remobilisation plans, there is a mental health treatment remobilisation plan that refers specifically to people who have drug and alcohol needs. Although I reassure Mr Stewart that drug and alcohol services are part of the remobilisation plans, many of those services have, in fact, found ways to remain open during the pandemic.

The Convener: Emma Harper has a supplementary.

Emma Harper: I am aware that, as the minister described, alcohol and drug services have stayed open during the pandemic. As part of the Covid vaccination process, are people who experience harmful effects as a result of drugs and alcohol issues, such as vascular issues or chronic obstructive respiratory disease, being prioritised so that they can enter recovery, rehabilitation or residential programmes such as Auchincruive in Ayr or Phoenix House? I am seeking clarity on the vaccination priority for people who are experiencing issues as a result of harmful drug use.

Angela Constance: Ms Harper will be aware that vaccination priority relates to age and health conditions. She is right to point to the relationship between drug use and increased physical health problems, particularly respiratory problems. The physical health problems that go along with drug use can be heightened for women.

With regard to the vaccination programme in general, many people who have an addiction will,

if they have physical problems, fall into a category that means that they are more of a priority for vaccination than younger, fitter people.

The real issue with the vaccination programme is how we reach those who are hard to reach. That is not just an issue in relation to people who have addiction problems, but a broader issue in relation to communities that are more adversely affected by poverty and inequality. Every health board's vaccination plan will take into consideration how we reach those people. The Deputy First Minister is leading on-going work in Government—again, across portfolios—on public services, and we remain vigilant to ensure that we reach people who are hard to reach.

Primary care services have a role in that, too. Addiction services will be able to support people who have engaged with treatment to access vaccination when they are called to do so. However, not enough people are involved in treatment, so general practitioners and primary care services can play an important role by identifying and reaching people who are physically vulnerable, whether as a result of drug addiction or other reasons. A higher number of people with drug use issues are registered with a GP than are registered with a drug and alcohol addiction service.

Donald Cameron (Highlands and Islands) (Con): I take the opportunity to acknowledge the minister's cross-party engagement, particularly her engagement with me, in the past month since her appointment at the end of last year.

My question is about the causes of drug use and drug dependency. I appreciate that you have covered some of these points already, minister. How will the factors that cause drug use and dependency be addressed on a cross-portfolio basis? I am thinking about issues such as poverty and the need to reduce childhood adversity, improving housing and employment prospects, and addressing mental health?

Angela Constance: A core part of that is about how services—especially health and education, as the big universal services—engage with and support families that may be struggling in some shape or form.

11:00

In 2019-20, the Government targeted investment of almost £2 billion at low-income households. I am familiar with the work on child poverty because I took the Child Poverty Scotland Bill through Parliament a few years ago. Our plan, "Every child, every chance: The Tackling Child Poverty Delivery Plan 2018-22", lays out actions that put money into people's pockets, reduce living costs and support affordable housing. It also has clear measurements of the impact of child poverty, which I reiterate is dealt with across portfolios. The social renewal advisory board led by Aileen Campbell and Shirley-Anne Somerville will be an important factor in that.

Drugs policy must be joined at the hip to certain areas of Government. I spoke a lot about mental health and how Clare Haughey and I will work together on that. Maree Todd's work as the Minister for Children and Young People allows the possibility of interventions that focus much more on families and provide a whole-family approach.

Much of the work sits in the context of our becoming a more trauma-informed nation, with our big universal services in particular being much more trauma-informed so that they include folk with difficulties, rather than inadvertently pushing them away.

Donald Cameron: Thank you for that detail. All cross-portfolio work requires co-ordination between the ministers and officials working on it. How is that co-ordination happening?

Angela Constance: That is my job. That is why I was keen to pull together a cross-government implementation group. I started using that approach a few years ago in our work with Gypsy Travellers. You have to ensure that you have all the right folk in the room, particularly people who can make decisions and be agents for change not only in Government, but in the community and across local government and the health service. All that cross-portfolio work must be well rooted in and plugged into our formal and informal work with communities with lived and living experience.

Donald Cameron: How will the additional funding that has been announced by the First Minister be used to support prevention and early intervention?

Angela Constance: That additional money is sharply focused on the emergency work that is required to save lives. As I have intimated a number of times, that must be plugged into the work that will not only save lives, but improve lives.

That brings us to the nuts and bolts of cross-government work. It is not only about how much of my portfolio budget is spent on prevention; it is about what is spent on prevention across Government, whether that be in health or in education.

I have spoken to Maree Todd about the launch in February of the £4 million promise partnership fund. Given the families who are likely to access the fund, we must ensure that they are also connected with the family support delivery group, which is connected to the work that is being done in drugs policy.

This is not just about how much of my budget is spent on prevention: there is a bigger question about how much health and education are spending on prevention.

David Torrance (Kirkcaldy) (SNP): My questions are around children and young people. What estimates does the Scottish Government have of problematic drug use among children and young people?

Angela Constance: The Growing Up in Scotland study shows that, historically, young people are participating much less in risky behaviour. More recently, we have the "Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS): Mental Wellbeing Report (2018)". The report is interesting because it shows that most pupils have never used drugs at all and that the number of pupils reporting using drugs has been gradually decreasing since the early 2000s.

However, there are always some wrinkles in those broad statistics, although they show a reassuring direction of travel. When we scratch below the headline statistics to the detail, we find that, for example, since about 2013, there has been an increase in the proportion of boys who report taking drugs in the previous month. We also know from the drug-related death statistics for the under-25s that there has been an increase in the number of young people dying in each of the past two years.

That group's pattern of drug use is different in that they are far less likely to use opiates but are more likely to use drugs such as MDMA and cocaine. The number of hospital admissions of those young people has gone up by 48 per cent. As with the general population who have addiction issues, there are big challenges around ensuring that when young people present at hospital because of an emergency issue, which might be a cry for help, we plug them much more quickly into the treatment and support that is right for them.

David Torrance: You have partially answered my next question. Are any specialist treatment services available for children and young people?

Angela Constance: The specialist approach is around family-inclusive practices and services that take whole-family and trauma-informed approaches. Our universal services, whether in health or education and whether for young people or adults, seek to ensure that those who present with challenging behaviour are not pushed away and that ways are found to keep them engaged with the services.

There is interesting research about the best way to empower young people to make positive choices. That tends to be around skills-orientated work in schools that targets a range of potentially risky behaviours by giving young people the skills, confidence and self-esteem to make positive choices. That curriculum for excellence work in schools is crucial, and I know that the part of it on educating about substance misuse is being looked at again.

People will be familiar with the work in and around the Know the Score website, for example, and the work done by Crew 2000 in engaging young people and educating them about a range of risky behaviours. However, work is also going on to reappraise prevention and substance misuse education in schools.

David Torrance: This is my final question. How does the Scottish Government's work in relation to drugs policy align with work to reduce adverse childhood experiences and levels of child poverty?

Angela Constance: I spoke a wee bit earlier about the work across Government to reduce child poverty. Unless there are specific points that Mr Torrance wants me to pick up on, I will not test the convener's patience by repeating that.

On the work around adverse childhood experiences, that alignment is crucial. Any time that you speak to any individual with lived or living experience, or to any of the organisations in the sector that are working with or that represent people whose lives are affected by drugs, they will tell you that the link to adverse childhood experiences is right up there as a factor. The work around getting people into the right treatment and around medication-assisted treatment standards is really important, because the MAT standards recognise that it is not just about giving people informed choices in relation to medication, but about making links to other treatments and support. They also recognise that access to any treatment needs to be quick.

The work on ACEs and MAT standards is really important to embed. It is high-priority work, and I think that that is the best way to demonstrate how to put a human rights approach into practice.

George Adam (Paisley) (SNP): The First Minister has announced an extra £5 million for drug services in this financial year. There was also a promise, should the Scottish National Party form the next Government, of £250 million over the next parliamentary session. That is not the only money that goes towards the partner agencies that you work with. Do you know how much money, on top of the money that the Government is putting in directly, goes to drug services? What is the total amount of money that is going into drug services currently?

Angela Constance: Mr Adam is correct that we have made a commitment of £250 million over the lifetime of the next Parliament and that £5 million in emergency money has been made available in

the last quarter of the current financial year, which is additional to the existing budget.

I can understand why the committee is interested in the total funding pot, and it is comparatively easy for Government to release information about our budgets, our spending and where we have directed funding. The picture gets a bit more complex when there is public money that comes from health boards in addition to Scottish Government resource, and there is local government investment as well. I am conscious that all that, at the end the day, is public money.

I cannot give you, here and now, off the top of my head, hard and fast figures that include health board and local government spend. I can say that part of the evaluation work that I spoke about earlier, which looks at the success and the outcomes of the national mission, is about better understanding the overall financial package.

11:15

For my part, I will publish as much information as I can. In the next week or so, I will publish details of the £3 million of extra money that is being allocated to alcohol and drug partnerships. There will be breakdowns from each health board area and each alcohol and drug partnership within those. People will be able to see where that money has been allocated. We made a particular ask about the proportions in which money would be allocated to aspects such as residential rehab, improving access to services and harm-reduction methods.

George Adam: My final question is on the back of what the minister has just said. How will the effectiveness of the additional spend be assessed? Partner organisations might spend the same money on similar issues. How will we ensure that we get as much as possible for every penny that is spent on alcohol and drug services?

Angela Constance: We need to have a forensic focus when we are following the money. I want to be absolutely sure and confident that we will get additional impact from the money that the creation of my portfolio has generated. It will be a case of me getting down to brass tacks and following the money that flows from the Government to ensure that we get additionality for that. That will be part of the work that we do in the evaluation programme on the national mission.

Liam McArthur: This is my first opportunity to welcome you to your new role—congratulations on that. I know from our previous work together in the education field that the collaborative approach that Donald Cameron mentioned in his comments is one that you will bring to this portfolio, too.

You will be aware that, last week, the Royal College of Physicians of Edinburgh published a report that, among other things, backed the introduction of safe consumption rooms to tackle the record level of drug deaths. As well as pointing to support for decriminalisation of drug use, Professor Angela Thomas, the acting president of the college, commented on the report, saying that

"key interventions which can be taken now"

include

"the introduction of a drugs consumption room, and a heroin assisted treatment programme in all major centres in Scotland as we see already at the Glasgow pilot scheme."

It might be early days, but have you had any engagement with the RCPE yet, or are you planning to speak to Professor Thomas and her colleagues as part of that collaborative approach so that we might see progress on the issue of safe consumption?

Angela Constance: The Royal College of Physicians of Edinburgh's report is important and welcome. It is encouraging that, even from a clinical point of view, there is acknowledgement of the role of poverty and inequality in all of this. Among clinicians, there is a deep understanding that the emergency work that they have to do to save lives needs to be embedded in every policy area across the board. There are various royal colleges that I will seek to engage with. I have certainly spoken to a range of clinicians who, as individuals, are involved with those colleges.

It is interesting to note that all the expert reports or pieces of evidence that are published have the same direction of travel. Some of that is about reinforcing what we already know about the benefits of, for example, heroin-assisted treatment and overdose prevention facilities. Such facilities save lives, but they also help people to get into longer-term treatment and to make longer-term improvements to their lives. They enable people to have more choices and chances. Although, in many ways, the RCPE's report did not tell us anything surprising, it is another layer of evidence for the direction of travel that should be taken.

My approach is that, where I can do something, I will. The example of overdose prevention facilities is apposite. I will continue to work to find ways to do things, where the route might be less than obvious or where there are legal barriers. Where we can do things, such as with the heroin-assisted treatment, we will progress as speedily as possible.

Liam McArthur: Thank you for that response, which tends to suggest that we know what the direction of travel is. Progress might be frustratingly slow, but I hope that we will get there eventually.

In the meantime, the Lord Advocate has quite a lot on his plate at the moment, but will the minister commit to engaging with him on what more might be done on the advice that the Crown Office issues on the law as it stands? That might provide more scope and reassurance to those who are delivering services that are clearly saving lives, albeit in Glasgow only at this stage.

Angela Constance: Yes, I have engaged with the Lord Advocate and the law officers, as you would expect. The Government's policy position remains the same. The law officers are fully aware of the Government's policy position. Those committee members who were involved in the Scottish Affairs Committee work will be aware of the Lord Advocate's views and of what the legal barriers are. Nonetheless, the law officers and the Lord Advocate in particular gave a view on a specific proposition to deal with the circumstances that are being fought in Glasgow, where vast numbers of people are injecting and are involved in high-risk behaviour. The Lord Advocate gave a view on that specific proposal, which from the Glasgow health and social care partnership.

I will look at alternative propositions, and I will continue to engage with the law officers. Officials are actively engaged in that stream of work. I appreciate and share folk's frustration about the situation. You will not be surprised to hear me say—this is a practical point as opposed to a political one—that I would much rather have the powers to legislate so that we could work together on legislation to provide a safe, legal environment not only for people who use overdose prevention facilities but for folk who would work in such a service. However, that will not stop me looking at alternatives and other opportunities to make progress on the matter.

The Convener: I thank Angela Constance and her officials for their attendance. Clearly, the area is one that will continue to be a major policy focus in the next session of Parliament. It has been a useful evidence session.

Subordinate Legislation

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2021 (SSI 2021/60)

11:24

The Convener: We move to agenda item 2, which is consideration of subordinate legislation. There are two negative instruments before the committee, the first of which is SSI 2021/60. Do members have any comments to make on the instrument?

As there are no takers, does the committee agree to make no recommendations on the instrument?

That is agreed. Thank you very much.

Food Information (Scotland) Amendment Regulations 2021 (SSI 2021/70)

The Convener: The second instrument is SSI 2021/70. Do members have any comments to make on the instrument?

As members have no comments, does the committee agree to make no recommendations on the instrument?

That is agreed. Thank you very much.

European Union (Withdrawal) Act 2018

Nutrition (Amendment) and Food for Specific Groups (Food for Special Medical Purposes for Infants, Infant Formula and Follow-on Formula) (Information and Compositional Requirements) (Amendment) Regulations 2021 (SI 2021/168)

11:25

The Convener: We move to agenda item 3, which is consideration of a consent notification that proposes that the Scottish Government gives consent to the United Kingdom Government legislating using the powers in the European Union (Withdrawal) Act 2018 in relation to a UK statutory instrument. The regulations postpone the date of application for new European Union requirements on infant formula and follow-on formula made from protein hydrolysates in line with a recent European Commission decision.

The instrument was laid at Westminster on 19 February and came into force on 21 February. The Scottish Government has advised that, because of the urgent need to make the amendment to retained EU legislation before 22 February, prior parliamentary scrutiny of the notification was not possible on this occasion.

Do members have any comments to make on the consent notification?

As members have no comments, is the committee content to write to the Scottish Government to indicate that we are content with the consent proposal and the regulations?

That is agreed. Thank you very much.

Subordinate Legislation

Health Protection (Coronavirus) (International Travel) (Managed Accommodation and Testing) (Scotland) Regulations 2021 (SSI 2021/74)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 6) Regulations 2021 (SSI 2021/81)

Health Protection (Coronavirus) (International Travel) (Managed Accommodation and Testing etc) (Scotland) Amendment Regulations 2021 (SSI 2021/107)

Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 7) Regulations 2021 (SSI 2021/111)

11:26

The Convener: Agenda item 4 is consideration of further subordinate legislation. We have before us four made affirmative instruments on coronavirus and international travel, which have been laid under section 94(1) of the Public Health etc (Scotland) Act 2008, which is on international travel. The 2008 act states that such regulations are subject to the affirmative procedure, except that that procedure will not apply if ministers consider that the regulations need to be made urgently. In such circumstances, they will be emergency regulations and will cease to have effect on the expiry of the period of 28 days, beginning with the date on which they were made, unless, before the expiry of that period, they have been approved by Parliament.

It is for the Health and Sport Committee to consider the instruments and report to Parliament accordingly. In other words, the instruments before us are of the same family as many of the instruments that we have considered over recent months. Last week, we took evidence on Covid health protection travel regulations from travel, hospitality and public health representatives. Today, we will hear from the Cabinet Secretary for Transport, Infrastructure and Connectivity on the same issues.

The regulations impose new requirements for self-isolation and mandatory testing for travellers who arrive directly into Scotland from outwith the common travel area, having departed from or transited through an acute risk country. They also make requirements for a managed self-isolation

package to be applied to persons who travel to Scotland from England, where they would otherwise be required to comply with equivalent regulations in England. Finally, they remove the Falkland Islands from the list of acute risk countries and territories in schedule A2 of the international travel regulations.

Those are the matters before us. In order to assist our scrutiny, I welcome to the committee Michael Matheson, Cabinet Secretary for Transport, Infrastructure and Connectivity, who is accompanied by, from the Scottish Government, Craig Thomson, border measures review team leader; David Pratt, policy lead for the health performance and delivery team; and Peter Brown from the police enforcement, liaison and performance team.

We intend to ask questions on all four instruments together. Questions might therefore be more general in nature, although some might relate more specifically to individual instruments.

I invite the cabinet secretary to make a brief opening statement.

11:30

The Cabinet Secretary for Transport, Infrastructure and Connectivity (Michael Matheson): Good morning. I made a statement to the chamber on 9 February, in which I set out the Scottish Government's intention to introduce a comprehensive approach to managed isolation of international arrivals. The regulations that we are discussing today give effect to the policy that I announced in my statement.

The principal managed accommodation regulations—SSI 2021/74—make it a requirement for non-exempt passengers who arrive in Scotland to enter at specific airports and to have booked accommodation in a managed isolation facility to undertake their 10-day isolation period. That applies to all direct arrivals and not just those from red list countries. The managed isolation package includes a requirement to take two polymerase chain reaction tests, on day 2 and day 8 of isolation. Positive test results are prioritised for genomic sequencing to give us an enhanced surveillance regime to monitor importation of variants of concern. Most exemptions from isolation for essential workers also require passengers to have booked and undertaken a testing package.

The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 6) Regulations 2021 make additional technical changes to clarify the application of the rules on travel within the common travel area. That includes the need to take account of red list country arrivals to Scotland who have not been correctly identified at the point of entry into the UK. That instrument was supplemented by the third instrument, SSI 2021/107, which makes further technical changes to definitions of testing and offences, and introduces an exemption for managed isolation for offshore workers in the North Sea who have transited through other countries. Those workers must now self-isolate at home when they return to Scotland.

The final instrument, SSI 2021/111, removes the Falkland Islands from the list of acute risk countries and territories. That decision was taken on the basis of a revised risk assessment from the joint biosecurity centre.

I am happy to respond to any questions that members might have.

The Convener: Members will have questions, but I want to begin by returning to some of the evidence that we heard last week when we discussed the different approaches across the UK. As you highlighted, there are different requirements in relation to red list countries and the overall approach for Scotland, where regulations apply to everyone who enters the country from all over the world.

There will have been discussions with other Administrations about the correct approach to take. Will you summarise the arguments for and against the red list approach and explain why the UK Government has favoured that approach? What are the reasons for the Scottish Government's preferred approach?

Michael Matheson: Please bear with me, convener—this might be rather a long answer, because I think that it is important to give you the background.

When we suspended the travel corridor system, which was operated on a four-nations basis across the UK, we did so because the joint biosecurity centre, which had been advising us on the travel corridor system, informed us that, given the emergence of new variants, especially the variants of concern in South Africa and Brazil, the methodology that it had been using for assessing the travel corridor system was no longer fit for purpose—it said that it was no longer suitable for the purpose for which it was intended. As a result, the travel corridors were suspended, as the committee is aware.

The joint biosecurity centre was then asked to develop a methodology that would allow it to identify countries that were at risk of having the new, emerging variants of concern. After carrying out that process and producing a methodology that was considered by the four chief medical officers of the UK, the joint biosecurity centre advised the four home nations that it was unable to develop a methodology that would have a level

of confidence that would enable us to use it for the application of a red list system. As a consequence, the chief medical officers in Scotland and the other UK nations were unable to recommend proceeding with a red list based system. There was very low confidence in the use of that method.

As a result of that, the Scottish Government received the advice—in line with what the scientific advisory group for emergencies highlighted—that the only suitable mechanism for minimising the risk of introducing variants of concern would be the introduction of a comprehensive managed isolation programme. On the basis of the advice that we received directly from our chief medical officer, we proceeded with the approach of introducing a comprehensive managed isolation programme.

We raised concerns about the UK Government's approach—given that the joint biosecurity centre had already advised that it could not develop a methodology that would have a significant level of confidence with regard to minimising new variants of concern—of introducing a geographically specific red list system. However, the UK Government has chosen to take that approach.

The approach that we have taken in Scotland is in line with the advice that has been provided by SAGE and by our chief medical officer, and with the advice that has been promoted by the directors of public health in Scotland. In our view, it is the most effective way in which to reduce the risk of the introduction of new variants in Scotland and the UK as a whole.

The Convener: In brief, would it be fair to say that your approach is based on the advice of the joint biosecurity centre and of SAGE, and that the UK Government's decision has been taken in spite of that advice?

Michael Matheson: That would be a fair reflection of the situation at the moment.

The Convener: If a red list approach continues to be operated for people travelling to England, what impact will that have on the comprehensive managed isolation programme approach that has been taken in Scotland?

Michael Matheson: Given that the UK Government chose to pursue the red list system, we made representations to it to ask that anyone who enters a port of entry in England and will travel on to Scotland be required to use a managed isolation facility in England for the purpose of their quarantine period. The UK Government has refused to take that forward. That presents the challenge that individuals who have been overseas, but who are not coming from red-list countries or have not transited through red-list countries, are able to arrive at airports or ports in England and then transit on to Scotland.

However, when they do so, they are required to self-isolate at home and to purchase a testing package for when they return home. To reduce further the associated risk, we have also increased the level of contact that is being made by the national contact tracing centre with those who return to Scotland following international travel where they are self-isolating at home. Over the past couple of weeks, we have reached approximately 96 per cent to 97 per cent of all those who return to Scotland following international travel being directly contacted by the national contact tracing service.

However, we continue to press the UK Government to introduce a more comprehensive system of managed isolation, given the risks that its existing system poses, not just for Scotland but for other parts of the UK, in light of the advice that we have received from our clinical advisers and the joint biosecurity centre.

The Convener: In practice, therefore, there are two classes of people who have returned from international travel to Scotland, one of which is people in managed isolation after landing at a Scottish airport; and the other being people self-isolating at home because they have come into Scotland by a different route.

Michael Matheson: There are actually three classes. There are those who arrive directly into airports in Scotland and go into managed isolation, and those who arrive at airports in England but not from a red list country and who then transit on to Scotland. There are also those who arrive at airports in England who have come from or transited through a red list country. They should be identified at their point of entry in England and be required to use managed isolation in England. The red list system operates on the basis of the point of arrival into the country rather than someone's destination after arriving in the UK. There are technically three layers here: those who come from red list countries intending to come to Scotland, who have to self-isolate when they come into England; and the other two categories that we just touched on.

The Convener: That is a helpful clarification.

I have another question before I pass over to colleagues. Given that different parts of the world have different quarantine periods, have you and your advisers considered the length of stay in quarantine or isolation for travellers arriving in Scotland?

Michael Matheson: The 10-day period is based on the clinical advice that we received towards the end of last year that the risk of moving the self-isolation period from 14 days to 10 days was significantly lower than had originally been understood when the 14-day period was

introduced. The advice from clinical advisers was therefore that a period of managed isolation should be 10 days, or 11 nights, which is in line with the period of self-isolation for anyone who is identified as being positive with Covid-19.

David Stewart: I will raise a big-picture issue that I have to confess I have been working on heavily for the past six months, which is about having an internationally recognised vaccination passport to open up international travel. The cabinet secretary will know that tourism is the most important asset and product of my Highlands and Islands region, so I am looking to a future of tourists coming safely to our area and Scots travelling all over the world safely.

You might know that I have raised the issue with the Cabinet Secretary for Health and Sport and Professor Jason Leitch at the COVID-19 Committee, and with Professor Linda Bauld and the First Minister. I am interested in the project, but I am realistic, because I understand that ethical and practical issues are involved. There is the issue of vaccination apartheid, by which I mean the poorest developing countries not having access to vaccinations. However, as you will know, we have a track record on issues such as yellow fever vaccination, and the World Health Organization is vital in that regard.

I am sorry for the long lead-in, but I think that a vaccine passport is vital to redevelop the economy and tourism, not just here but across the world. I have shown my bias to you strongly at the start, but what are the Government's thoughts on a vaccine passport, where we are with the issue and how we can develop it?

Michael Matheson: I recognise Mr Stewart's interest in the matter of vaccine passports, which could play an important part in re-establishing international travel. As you rightly highlight, there are a number of ethical issues with the idea of vaccine certification or, as it is often referred to, vaccine passports. However, I think that they will have a part to play at a later stage in the months ahead.

11:45

We are already engaged with the UK Government on the matter, and I have indicated through the regular Covid operations, or Covid-O, committee meetings that we are looking to work on a four-nations basis on the development of any vaccine certification process. Our officials in the Scottish Government are also engaged with the World Health Organization on the matter. The WHO is looking to develop a set of data-specific regulations that could be applied universally across the world to a vaccine certification programme, similar to that for yellow fever. The WHO is trying to create a system that could work globally, and we are engaged in that process.

I agree that vaccine certification will have a role to play in the recovery of international travel, and we are engaged in the process. However, the benefits of such a programme do not remove some of the risks that are still associated with variants of concern, and they are dependent on the scale and nature of vaccination that is taking place in other countries across the world. As you rightly say, there is a danger that some countries are significantly behind others with the roll-out of vaccination, which could have a significant impact on people's ability to travel in other parts of the world.

We are already looking to develop our thinking around how vaccine certification would operate through the data system that we have in NHS Scotland. We must also be mindful of the associated ethical issues, and recognise that it is not a replacement for measures such as self-isolation in helping to reduce the risk of introducing new variants into the country.

David Stewart: The cabinet secretary has been very open and honest on the subject. My comments generally are not made in a party-political way. I am enthusiastic about the matter, but my eyes are open to some of the downsides.

I will give my honest view. I have been watching carefully what has been happening in Europe, particularly with the Greek Prime Minister pushing the EU ahead on vaccination certificates. I also believe that industry will go ahead with them, almost irrespective of what is happening. My real worry is that the Scottish Government is at the station, but the train is already leaving. I am worried that we are falling behind on the issue. Notwithstanding some of the practical concerns, I am concerned about the issue in terms of travel. I do not want a vaccination certificate in relation to access to services—there are different arguments for that. Does the cabinet secretary recognise my frustration on the issue?

Michael Matheson: I would recognise your frustration if we were not already progressing the issue, but we are. We are already engaging and looking to take forward the matter on a four-nations basis.

My only note of caution is that it is far too early to say that it will be possible for Greece to welcome people from the UK this summer if they have a vaccine certificate, as ministers in Greece say they are looking to do. We do not know what the state of the pandemic will be at that point, either domestically or in Greece. We also do not know what stage the vaccination programme in Greece will be at. Therefore, there are a number of factors that will influence matters.

I reassure Mr Stewart that we are already engaged in a detailed way on the potential role of vaccine certificates and how we could use our existing data system in NHS Scotland to operate on a four-nations basis. Engagement among officials is already taking place. However, in my view, the practical operation of such a programme requires a level of international agreement to ensure that it operates effectively and adheres to the necessary data standards. There is still a considerable amount of work to be done at international and domestic levels to take forward the concept and the practical operation of such a system.

David Stewart: I turn to my final question, although the cabinet secretary might not have the relevant information to hand. I know from my experience in politics, for what it is worth, that we can all talk a good game—I am not saying that the cabinet secretary is doing that—but essentially we require two main things: funding and staffing. I have asked the chief executive of the health service about staffing, and to date I have not had an answer.

How many staff are allocated to the project, and what funding has been allocated to it? When I asked the Scottish Parliament information centre about that, it could not find any specific funding for vaccination passports, if my memory serves me correctly. The cabinet secretary will understand my frustration in that regard. Can he say something about that? Is anything more than a generalised discussion going on?

Michael Matheson: I can pick up the specific points that Mr Stewart has raised with the chief executive of NHS Scotland and ask for more specific information. I do not have such information to hand.

On funding specifically for staff in taking forward the project, I expect that that will be part of the wider Scottish Government funding arrangements for resourcing different parts of Government and taking forward policy. For example, there is no specific funding for the project team that has been put together for the managed isolation programme; the wider Scottish Government funding budget is being used for that. There may not be a ring-fenced budget for staffing, but we may have to provide a level of funding for the roll-out of a certification programme at a future stage, although we are probably still too far away to know exactly what that might be. I will take away Mr Stewart's points in order to see whether the chief executive of NHS Scotland can provide further details on the work that is being done.

David Stewart: Thank you.

The Convener: As you said, cabinet secretary, it is impossible to predict where things will be at any point during the coming summer. However, in your view, what circumstances would need to be in place at some point in the future before managed isolation and quarantine were no longer required?

Michael Matheson: First, I emphasise that we do not want to have managed isolation in place for any longer than it is needed. The trigger for ministers to start to move away from the use of managed isolation will be based on the clinical advice that we receive from our chief medical officer and our border health review group, which considers those matters in detail.

A number of factors will be important in determining that advice. One will be the roll-out of our own vaccination programme, and our understanding of the protection that the vaccine provides in respect of the transmissibility of the virus and its effectiveness against the new variants of concern.

Alongside that, we need to consider the prevalence of the virus in other parts of the world. We know that, based on the WHO's assessment, the pandemic continues to be out of control in a significant number of European countries. Opening up international travel will involve looking at prevalence levels in other parts of the world; where other countries are with their vaccination programmes; and, as Mr Stewart highlighted, the introduction of a vaccination certification programme.

All those factors will play a part in the assessment that the chief medical officer will use to advise Scottish Government ministers on the type of border health restrictions that we need to have in place in the months ahead.

George Adam: Following on from the convener's question, what are the latest numbers for inward flights to Scotland from red list and non-red list countries? How many people are staying in managed isolation? What are the quarantine hotel occupancy rates?

Michael Matheson: At present, there are no direct flights into Scotland from red list countries. Those flights are banned, on the basis that they would be coming from a red list country. However, flights are still coming into other parts of the UK carrying individuals who have transited through red list countries, and who are being identified at their point of entry.

As of midnight last night, we had 254 people in managed isolation in Scotland. In the past couple of weeks, the numbers have been gradually edging upwards. Overall, however, international travel directly into Scotland is at a very low level, as it has been for a number of weeks, in comparison with the levels of international travel that we had back in January. The numbers remain

very low, but the number of individuals who end up in managed isolation has increased slightly in the past two weeks. As I said, we currently have no direct arrivals into Scotland from red list countries.

George Adam: There is great concern among the public that people could potentially come into Scotland having gone through red list countries at some point. What communication have you had with the UK Government on that, and how have you made the case with regard to how we try to keep the populace in Scotland safe?

Michael Matheson: That is being taken forward in two ways, through my direct representations to the Covid-O committee and my written correspondence with Michael Gove at the Cabinet Office on the need to take a more comprehensive approach. We have some on-going issues with the UK Government. For example, at times, individuals transit through a red list country and arrive at an airport in England before transferring to a domestic flight and arriving in Scotland.

There has been some media noise around why we are bothering to have managed isolation at Glasgow airport when there are no international flights coming in, other than from the Republic of Ireland. It is for three reasons. First, individuals may be missed when they arrive at airports in London or in other parts of England, and then arrive at Glasgow airport. We have had several such cases. A number of individuals have transited from a red list country through Dublin and into Glasgow, and they have had to self-isolate at Glasgow airport. The third category covers those who cross into Scotland via the Cairnryan border point, on the ferry from Northern Ireland. We have identified a couple of individuals who have taken that route, and they have had to self-isolate.

There are still individuals arriving in Scotland from red list countries, and we have measures in place to identify them as quickly as possible and ensure that they go into managed isolation. However, as yet, we have not been able to persuade the UK Government to take a more robust approach to the managed isolation system in a way that is comparable to how we are operating in Scotland.

George Adam: That is all very concerning and worrying.

We had representatives of the airports and the hospitality sector before the committee last week. You had to create and put in place the managed isolation policy at speed. However, those witnesses complained that there was not enough consultation from the Scottish Government. What challenges did you face in developing and implementing the policy at pace? Are discussions now under way with the aviation and hospitality sectors in order to draw on lessons learned as a result of the haste with which you had to get the policy up and running?

Michael Matheson: I very much appreciate the concerns that were raised by the aviation sector, and in particular the airports, about the speed at which the policy had to be introduced. There are two parts to my answer. Some representatives of those sectors have challenged the Scottish Government on a lack of consultation in taking forward the policy. Given the clinical advice that we received, it was clear that the Scottish Government had to move quickly on the issue, and we sought to co-ordinate our approach with that of the UK Government.

12:00

From the time when it was highlighted to us that we needed to take action, to the implementation of the policy, there was no time for us to undertake a consultation on whether we should introduce it. The advice was clear. There were challenges that prevented us from being able to engage with our airports in a more detailed way—that was not the UK Government's fault. We agreed to take forward the managed isolation policy on a four-nations basis, under one single contract for the whole of the UK. That meant that the standards, the policy approach and the implementation would be consistent across all the airports in the UK.

Some of the process of managing that contract was taken forward by the Department of Health and Social Care, controlled by the UK Government, which limited the scope of our control over the roll-out of the policy implementation. Alongside that, parts of the enforcement of the policy were dependent on Border Force and had to be taken forward through the Home Office.

We did our very best to engage with our airports in the lead-up to the policy decision and when the policy was implemented, but there were constraints, because of the speed at which the policy had to be introduced and the fact that UK Government departments were taking forward key parts of it. As a result of that process, the level of information that we had at certain key points was limited.

I accept that the situation was far from ideal, but we sought to manage it as effectively as we could, to engage with the airports as much as possible and to provide as much information as possible when we had it to hand.

David Torrance: Good afternoon, cabinet secretary. Why has it been necessary to bring in a series of different regulations on a short timescale? Can you explain how they will all fit together?

Michael Matheson: We have introduced some of the regulations to close down potential anomalies in the system. As I mentioned earlier, individuals who arrive from red list countries into ports or airports in England and intend to travel on to Scotland should be identified by Border Force at their point of entry. The regulations were originally drafted on that basis. However, it then became apparent that some individuals were getting through the system, and the regulations had to be amended to ensure that individuals who arrive from red list countries on a flight from within the common travel area could be required to go into managed isolation when they arrived in Scotland. As I mentioned, that is one of the reasons why we have a facility at Glasgow airport.

Another reason that some of the regulations have changed is to accommodate some of the issues that the oil and gas sector raised. For example, individuals who work in the Norwegian sector often go from their platform straight to the airport, from which they then transit back into Scotland. On the basis of the clinical advice that we received, which was that the risks associated with that were very low, we sought to provide an exemption to accommodate those individuals and to allow them to self-isolate at home rather than in a facility.

Finally, we amended the regulations to take into account the change in the risk assessment for the Falkland Islands.

David Torrance: Can you indicate the degree to which there is now an understanding of the new rules? What is the plan to communicate those rules to the aviation and hospitality sectors, and to the wider public, in a simple and comprehensible way?

Michael Matheson: There is now information available on the Scottish Government's website, which provides details of the policy on managed isolation and the exemptions that are provided in the regulations.

The project team that is managing the managed isolation programme is in regular contact and dialogue with airports, hotel providers, transport providers and the security services that are providing support. It is ensuring that, where there are any issues of concern to the airlines, we pick those up through Border Force. In order to ensure that that happens, the Civil Aviation Authority is providing the correct information to airlines that have direct flights into Scotland.

We now have a range of measures in place to ensure that people can access the relevant information, and we maintain on-going engagement with the airlines and airports with regard to any issues that may emerge as we go forward.

The Convener: You mentioned that provision has been made to enable those who work offshore in the Norwegian sector to self-isolate at home on returning to Scotland, albeit that they are transiting through airports in Norway. I know from constituents of mine that there are also quite a number of Scottish oil and gas workers who work onshore in Norway. They have raised the question of why they face different requirements from their offshore colleagues, given the very tough border controls and very low prevalence of Covid in Norway. Have you considered that matter in the same context as the offshore workers in the Norwegian sector?

Michael Matheson: That was considered, and the clinical advice was that we should not make an exemption. As I mentioned, we currently exempt individuals who, when they arrive in Norway, have to go into a period of self-isolation. They then go on to their platform or vessel for their period of offshore working, and they will often transit back through the airport in Norway, from which they fly directly to Scotland. They are effectively only transiting through that airport for the purposes of returning to Scotland. That is different from the situation with individuals who are staying and working in Norway. The clinical advice that we received said that only those who are transiting through airports in Norway on their way back to Scotland should be exempt.

I am sure that you will appreciate that if we started to introduce what would effectively be a corridor system specifically for one group of employees in one country, we would then face demands for similar arrangements to be introduced for other groups of employees in other parts of the world. That would undermine the intention of our managed quarantine programme. We have taken forward an exemption system that is based on the clinical advice that we have received on the matter.

The Convener: I simply note that workers who are travelling from Scotland to Norway to work onshore are also required to isolate on arrival in Norway before they begin to work, even though their work is onshore. I am sure that your clinical advisers will be aware of that.

Donald Cameron: Good afternoon, cabinet secretary. I begin by asking about the governance of this work within the Scottish Government, in the light of the fact that it cuts across portfolios. For example, there is a division of responsibility between health and transport. How is that working internally?

Michael Matheson: The governance process that we have in place for these matters is led through the border health review group. It is made up of officials from health, justice, transport and external affairs, who consider all the different

component parts of our border health restrictions. The restrictions are reviewed every 28 days, in line with the regulations that we introduced earlier this year. The review group brings together all the different disciplines in order to advise us on the issues, and we have the 28-day review period in which to determine whether restrictions need to be maintained as we move forward.

Donald Cameron: I will move on to the four-nations approach. Last week, we heard powerful evidence from Mark Johnston of AGS Airports, who said that he is looking for a system that is "simple and consistent". What have been the logistical challenges of a four-nations approach? I ask that in the context of the fact that Wales and Northern Ireland have taken an approach that is more similar to that of England than Scotland has. Have you had discussions with the Administrations in Wales and Northern Ireland in trying to overcome the logistical challenges?

Michael Matheson: Wales and Northern Ireland do not have any international flights coming into their airports at present, so they do not require to have a managed isolation programme in place, although my officials have been engaging with them, because they have asked for advice from us on our experience of introducing the managed isolation programme.

On your specific point about the logistics of introducing the measures, those have been significant. The practical operation has involved putting in place hotel, transport and security arrangements; ensuring that Border Force staff were appropriately trained and informed of the way in which the regulations operate; and introducing a booking portal system so that individuals, prior to their departure, can book their period of managed isolation or their testing package. All of that had to be put in place at very short notice. All those arrangements have presented significant practical and operational challenges but, by and large, staff have introduced them very well.

As a transport secretary and as an infrastructure secretary, I am well aware of the types of challenges that can arise with such operational issues. However, by and large, the system has operated very well since it was introduced, although some changes still need to be made to the operational arrangements, particularly around the welfare fund arrangements, on which we are continuing to work with the UK Government.

We sought to work on a four-nations basis to try to minimise the operational risks of different parts of the UK having different standards and charges for the introduction of managed isolation packages and testing packages.

Donald Cameron: If the other three nations of the United Kingdom maintain their current approach, what will be the options for the Scottish Government? I am thinking particularly of the issue that we all acknowledge about someone flying into, say, Newcastle or Manchester—or Belfast when that is allowed—and then travelling on to Scotland, and being required to isolate only at home rather than in managed accommodation. Are you considering any legislative option in that respect?

Michael Matheson: It is worth keeping in mind that, as I pointed out, the Northern Irish and Welsh do not have any international flights at present, so they are not dealing with individuals who travel into the country from overseas. I know that the First Minister of Wales has indicated that he would prefer a green list system rather than a red list system. I think that there is some merit in that for managing our exit from use of managed isolation.

The important thing, however, particularly for a committee such as this one, is that the lessons that we need to learn from the pandemic are about the need to move early and to do so decisively. If the clinical advice is clear and strong that we need to have in place a comprehensive programme of managed isolation, particularly during the roll-out of a vaccination programme and given the risks associated with variants of concern, it is incumbent on ministers to respond to that. That is exactly the approach that we have taken in Scotland—we have tried to effectively implement the clinical advice that we have received. I have no doubt that, had I been invited to speak to the committee and said that I was ignoring that clinical advice, the committee would have significant concerns about that.

12:15

In general, the key issue will be how we manage our exit from the use of managed isolation and start to ease the restrictions, and ensure that the approach that we take in Scotland and the approach that is taken in England are as aligned as possible, and based on the clinical advice and data around where the pandemic is at any given time. We are probably still some way away from that.

We are continuing to press the UK Government to introduce a more comprehensive system, which would be safer for Scotland and other parts of the UK, based on the expert clinical advice that we have all received.

The Convener: When you talk about the potential for a green list and how it might apply to countries with low prevalence and secure travel, I am bound to come back to my constituency interest in the situation in Norway.

You mentioned that the Joint Biosecurity Centre and SAGE have found no basis for a red list. Have they been consulted, or have they given advice, on the potential of having a green list as a way out of the current situation?

Michael Matheson: They have not. It is important that the committee is aware that the Joint Biosecurity Centre has already carried out a review of the existing red list countries and submitted to the UK Government a report on that review. However, to date, the UK Government has withheld that report from us. I have made representations to the UK Government on the matter, and I know that colleagues from the other devolved nations have also done so. The Joint Biosecurity Centre works on a four-nations basis, but the report was submitted to the UK Government.

The most recent review of the red list countries by the Joint Biosecurity Centre has been withheld from us, and we continue to press for the advice to be provided. At this stage, it has not been commissioned to consider the creation of a green list system. I am suggesting it only on the basis that the Welsh First Minister has also suggested it, and I think that there is some merit in exploring it. However, I am concerned that the expert advice from the Joint Biosecurity Centre on the existing red list system is being withheld, and that needs to be addressed urgently. At the Covid-O meeting just last week, I made representations to the UK Government and asked for the advice to be made available to us. However, to date, it has still not been provided.

The Convener: Could advice on a green list be commissioned by the Scottish Government alone, or would there have to be agreement among all four nations?

Michael Matheson: It would be best taken forward as a potential route out of the use of managed quarantine—alongside vaccination, prevalence rates and vaccine certificates—on a four-nations basis. The green list has a potential role to play. It may be that through the work that we are taking forward with the aviation sector through our aviation working group, and our engagement through the global travel task force, the issue will be explored further. However, at this stage, it is probably too early to say whether that is the route out—it might be one of a number of different options that could be considered.

The Convener: That is helpful. Emma Harper has a supplementary question.

Emma Harper: What does the cabinet secretary have in his toolbox to manage the practicalities of the Scottish and English border? Just before Christmas, the Kent variant spiked in Stranraer, and there were other wee outbreaks in Gretna and Annan. People have spoken about cross-border travel requirements for essential working or services.

Is there anything that the Scottish Government can do to manage the border in a way that supports keeping the virus suppressed on the Scottish side of the border, given that, previously, the UK Government released lockdown perhaps a bit faster than we would have liked?

Michael Matheson: I recognise Emma Harper's concern about that issue. One of the challenges in introducing specific checks at the border between Scotland and England is the volume of traffic that crosses the border daily, for a variety of purposes.

A key factor that can play a part is having a consistent message that people should travel only for essential purposes. I have raised concerns with the UK Government about some of the mixed messages about the possibility of people being able to travel for leisure purposes at various points. At this stage, it is important that all Governments in the UK continue to emphasise to individuals that they should travel only for essential purposes. If people comply with and adhere to that message, that will minimise the risk of transportation of the virus not only from England into Scotland but from Scotland into England.

All four nations need to be as consistent as possible in getting that message across to the public. We regularly discuss with our counterparts in other parts of the UK the need to ensure that we provide that consistent message, and it has been quite frustrating on the occasions when that has not happened. It is key that we maintain that message in order to reduce the risk of people travelling unnecessarily between Scotland and England and between Emma Harper's region of Scotland and Northern Ireland.

Sandra White: Good afternoon, cabinet secretary. I have a couple of questions about the testing regime. In answer to Donald Cameron, you mentioned the operational challenges relating to managed isolation and the "testing package", as you called it. PCR tests are conducted on the second and eighth days of people's isolation, and the tests are self-administered. Will people who are in quarantine be supervised when they undertake the tests themselves to ensure that they are conducted properly? Who gives them the tests, and who receives them? Basically, who is responsible for looking after the tests and the results?

Michael Matheson: The test is self-administered, so people are not supervised when the test is carried out, either in managed isolation or at home. In a managed isolation facility, the test is returned to security staff at the hotel, who pass it on to a lab where tests are carried out. I am

afraid that I do not know, off the top of my head, which lab tests go to directly, but I could check, if that information would be helpful to Sandra White.

If the result of the test is negative, that information is shared with Public Health Scotland. If the result of the test is positive, Public Health Scotland will require genomic sequencing to be done in order to see whether it is a variant of concern. If it is, there is a standard process for dealing with that through the local health board, its incident management team and the security providers at the airport. The results are collated by Public Health Scotland.

If the result is positive, the individual concerned will be notified, genomic sequencing will take place, and the local health board will be engaged in any management issues associated with that individual, whether they are in managed isolation or self-isolating at home.

Sandra White: Basically, people take the tests themselves—although in Glasgow, for example, people would go to NHS Louisa Jordan. People are handed the test by security staff from private firm G4S—that is a UK four-nations approach. I take it that the tests are stored in the hotels to be handed to people in their rooms and that people then give the tests back to the security staff from G4S, before the tests are sent somewhere. We do not know—I would really like to know—which testing centre they are sent to. How quickly can these results be processed? If the result is negative, that is not necessarily fine, but it goes through Public Health Scotland, and if the result is positive, Public Health Scotland is responsible, but it must go through the four-nations process again. Is that correct? Is that what happens? We do not know whether people are taking the tests properly, if there is no one there to supervise them.

The Convener: Craig Thomson might want to come in, as he has indicated knowledge of those issues.

Craig Thomson (Scottish Government): I want to build on what the cabinet secretary said. Those are UK home testing kits, which are specially labelled so that they are prioritised when they go into the UK Lighthouse lab system. Once they go into that system, as the cabinet secretary said, the results are passed on to Public Health Scotland for contact tracing. The turnaround time is generally within two days. The purpose of the test on day 8 is largely to ensure that, when the person gets to the end of the isolation period of 10 days, we have an assurance that they have tested negative. These are the same standard PCR tests as the home testing kits that are used in the UK Lighthouse lab system.

Brian Whittle: Good afternoon, cabinet secretary. What involvement has the Scottish Government had in the procurement process for managed quarantine services—for transport, security and hotels? Is the Scottish Government satisfied that all aspects, including facilities and quality assurance protocols, are specified to a high enough standard?

Michael Matheson: The contract for the delivery of managed isolation in Scotland, from the provision of the hotels to transport and security, is a single contract at UK level. The standard specification and operating procedures being used in Scotland are the same as those in other parts of the UK. There are some slight variations. For example, the information that guests who arrive in hotels in Scotland receive is Scotland-specific, so the contact and support helplines and the phone numbers for Breathing Space are Scotland-specific. It is a UK-wide contract with standard operating procedures, with minor variations to how it operates in Scotland.

With regard to standards, the contract specifies that the hotels will be three-star or four-star hotels. The contract sets out what the hotel provider must provide, alongside the responsibilities of the security provider and the transport provider. Those are operating well and to the specified standards. As I mentioned, there are some slight variations to the Scottish element of the operating procedures, which reflect some of the specific circumstances in Scotland. For example, the arrangement for individuals who are collected from the port of Cairnryan and transported to a managed isolation facility at Glasgow airport is specific to Scotland, because of that potential point of entry.

12:30

Brian Whittle: Thank you for that clarification. Who is monitoring the quarantine hotels to ensure that there is full compliance with the infection controls as stated?

Michael Matheson: Discussions take place between the project team, the Scottish Government, the UK Government and the hotel, security and transport providers several times a week. They cover any issues that have been highlighted to the project team, allow the UK Government to raise any issues with their project team and the operators and also allow any issues that operators have to be addressed. Engagement takes place every day to identify any operational issues or concerns that have been highlighted from our side or the operators' point of view, so that they are addressed quickly.

Brian Whittle: Do you have any concerns about potential weak links in the chain of infection control? I am thinking specifically of lessons from the Australian experience that indicated that hotel

transfers or the employment of private security staff might pose a risk.

Michael Matheson: Certain protocols are in place for security and hospitality staff. They are subject to daily testing prior to the start of their shift in order to identify early any risk of staff being infected. Alongside that, there are clear protocols for the hotels and security guards in managing individuals. For example, when hotel rooms are vacated by an individual they are left for three days before cleaning staff enter the room to clean it. Additionally, when individuals are being transported, appropriate levels of social distancing are required and masks must be worn on the coaches. Sometimes, more than one coach is used to take a small number of people to make sure that that is maintained.

The rules for hotels are clear. Individuals are not able to leave their room unless that is agreed with the security staff, in order to minimise the potential risk of them coming into contact with other guests and the staff. Meals are left at the door, rather than taken into the room. A range of different measures have been built in to minimise the risks as best we can, alongside the daily testing of staff to identify as early as possible any who become infected.

Brian Whittle: Can you confirm whether the managed quarantine programme comes at no cost to the Scottish Government budget or whether there are cost implications that we need to know about?

Michael Matheson: There will be a cost to the Scottish Government for the policy in the end. However, it has been taken forward in a single UK contract for the present. In the months ahead, the costs for the Scottish element of it will be disaggregated and met by the Scottish Government. At present, I cannot say what those finalised costs will be because the overall cost of the programme across the whole UK will emerge in the months ahead.

Emma Harper: My questions, which I will try to make succinct, are on the health and wellbeing of staff at airports, and about travellers being put into managed quarantine. What concerns do you have about the wellbeing of airport staff? What is being done to support the human rights and welfare of travellers moving through airports?

Michael Matheson: Our airports and airlines have had in place arrangements for some time to manage people moving through airports and on to and off of aircraft in order to try to maintain social distancing. Their protocols apply currently.

Alongside that, there is a process for individuals moving through airports and on to a managed isolation facility. There is a requirement for security staff, transport providers, and airport and hotel staff at the point of arrival to be compliant with the need to maintain social distancing and minimise the potential risk of direct contact with guests or travellers. The operating procedure seeks to minimise that potential risk and helps to protect the staff.

I know that my officials leading the project had a discussion—I think that it was towards the end of last week—with the trade unions that represent staff, particularly those working in hotels, who provide that service. They discussed the arrangements that are in place to protect hotel staff. The feedback that officials provided me was that, broadly, the unions were content with that.

I can assure you that, if any issues emerge that would be a matter of concern for staff welfare, I would expect those issues to be addressed quickly in order to minimise that risk.

Emma Harper: I note that the cost of the managed quarantine is £1,750 for the first traveller and £650 for an additional adult or child over 12. I am sure that part of the wellbeing and welfare concerns is that people have indicated that they might not be able to meet those costs. How do we support people who might need an additional welfare package or some support so that they are not burdened by the impact of an additional cost of £1,750?

Michael Matheson: There are two elements to that. The first is in relation to people who might not be able to afford the cost up front. If that is the case, they can choose a deferred payment programme in which they can pay the cost over an extended period. People who receive qualifying benefits, which would suggest that they are unable to meet the costs associated with managed quarantine, can also use that programme.

More work needs to be done to ensure that the welfare provisions are operating effectively and on the basis of how we want to operate them in Scotland. There are points of difference between the UK and Scottish Governments. For example, on the welfare arrangements for those who may be on benefits that qualify for a deferred payment, the UK Government's preferred approach is that the repayment will be deferred and deducted from their benefits. Our view is that individuals who may be on qualifying benefits will have the fee waived.

The UK Government's booking portal is not currently able to accommodate both those options and we are engaged with it to amend the portal so that it reflects the approach in Scotland—that is, for those who qualify for welfare support, where they are on a qualifying benefit, the fee is waived rather than deducted from their benefits. My officials continue to press to get the system amended in that way. I hope that that will be progressed in the coming days. We have been

trying to resolve the issue for a couple of weeks, as it is clearly a matter of concern for those who do not feel that they can meet the costs associated with managed isolation.

The engagement that we have had with the UK Government on that matter has been positive, but we have just not got to the point of making the changes to reflect the different approach that we want to take here around waiving fees for certain individuals.

Emma Harper: I have a wee final question. I am sure that the numbers that such an amendment to the system would require are small, but do the constraints of the UK Government's approach impact people who seek to come back to Scotland but have challenges around the fact that they might need that fee waived?

Michael Matheson: No, I do not think that they do. What will happen at present is that someone who is on a qualifying benefit will be able to indicate that they are looking for deferred payment, so the fee will not prohibit them. The issue is how we deal with that afterwards. The way in which the booking system operates now does not quite reflect how we want to deal with deferred payment, which is why we are looking to make some amendments to the system. I might be wrong, but I am not conscious of anyone who has been unable to return as a result of the existing arrangements.

If someone needs to get home, I am inclined for them to get home and deal with the finance issue later. The deferred payment system allows that to be happen; it is just about how we then follow that up. We need an amendment to the system to be able to waive the fees in certain circumstances for individuals who are on a limited number of qualifying benefits.

The Convener: Does the managed isolation welfare fund that you referred to earlier go beyond the deferral or waiving of fees, or is there more to it than that?

Michael Matheson: The fund is limited to the benefit criteria, although there are a couple of other exemptions for welfare purposes, for individuals in situations that do not require the use of managed isolation—for example, an individual who is returning on a family reunion visa and will be able to self-isolate at home, or someone who is coming to Scotland as a refugee or asylum seeker and has a designated place of residence to go to, where they can self-isolate. There are welfare provisions associated with the reason why the person is coming to the country, and those are separate from the provisions around the financial costs of the managed isolation package. I hope that that is clear.

The Convener: It is. You mention that you were not aware of cases in which people cannot return. I refer to the case of a student who has been in Germany for compassionate reasons and wishes to return to Scotland. She fears that she simply could not afford the fees for managed isolation in a hotel. Clearly, being a student does not of itself constitute being on a qualifying benefit, so what would the position be for somebody in her circumstances?

Michael Matheson: You are correct: being a student is not an automatic qualification for the scheme. I do not know what the person's wider circumstances are and whether they are on other qualifying benefits. There might be circumstances in which they could benefit from a deferral scheme if they were on the right benefits, but it would depend on their individual circumstance. Being a student does not in itself give someone an automatic right to have the fee waived, because there is a benefit qualification for any deferral scheme.

The Convener: Essentially, without a qualifying benefit, somebody in that position simply would not be able to travel.

Michael Matheson: If they were just travelling to the country for the purpose of returning home, they would not be automatically exempt from the cost.

The Convener: This session has been comprehensive. Thank you for your evidence today and the attendance and contribution of your officials.

12:45

I move to the next agenda item, which is the debate on the motions on the four made affirmative instruments on which we have just taken evidence. Members have previously agreed that we will take those instruments together. Are members content to hold a single debate covering all the instruments?

No member disagrees, so we move to the debate phase. Members and the cabinet secretary have an opportunity to speak, but not the officials.

Motions moved,

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Managed Accommodation and Testing) (Scotland) Regulations 2021 (SSI 2021/74) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 6) Regulations 2021 (SSI 2021/81) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Managed Accommodation and Testing etc.) (Scotland)

Amendment Regulations 2021 (SSI 2021/107) be approved.

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 7) Regulations 2021 (SSI 2021/111) be approved—[*Michael Matheson.*]

The Convener: I invite contributions to the debate on those four motions.

Brian Whittle: I just want to make the point that we are in danger of conflating a four-nations approach and the approach of the Westminster Government. When we talk about a four-nations approach, we have to be careful to talk about four devolved nations. That point is starting to rankle with me. A four-nations approach means that of four different nations, not just one.

The Convener: Thank you. No other member wishes to contribute, so I ask the cabinet secretary to sum up and respond to the debate.

Michael Matheson: I do not have any further points to cover.

The Convener: The question is that motions S5M-24146, S5M-24189, S5M-24262 and S5M-24253 be agreed to.

Motions agreed to.

The Convener: We will report to Parliament accordingly. I thank the cabinet secretary and his officials for their attendance today.

12:47

Meeting continued in private until 12:55.

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