



OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 17 November 2020

Session 5



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Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE

30th Meeting 2020, 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:

Jim Aitken
Julie Cuzen
Susan Dumbleton
Ron Goldie
Willie Rennie (North East Fife) (LD) (Committee Substitute)
Steve Sinclair
Dr Ann Wilson
Humza Yousaf (Cabinet Secretary for Justice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 17 November 2020

[The Convener opened the meeting at 10:00]

Social Care

The Convener (Lewis Macdonald): Good morning and welcome to the 30th meeting in 2020 of the Health and Sport Committee. We have received apologies this morning from Alex Cole-Hamilton; I welcome Willie Rennie as his substitute for the meeting. I ask all members to ensure that mobile phones are in silent mode and that all notifications are turned off during the meeting.

The first item on our agenda today is a round-table session in our inquiry into social care. Today, we will be hearing from individuals who are receiving care or who have caring responsibilities. It is, of course, hugely important for the committee to hear first hand from those with lived experience of social care. We are very grateful to those who have given up their time to join the committee this morning. I also thank our outreach team for identifying and supporting today's witnesses.

Last week, we published the results of our survey on the impact of Covid-19 on care at home. I am sure that some of the issues raised in that report will be relevant to our discussion today.

I am pleased to welcome to the committee Jim Aitken, Julie Cuzen, Susan Dumbleton, Ron Goldie, Steve Sinclair and Dr Ann Wilson. Thank you all for joining us today and for the information that you have provided to the committee in advance of today's meeting. I will start by inviting each of you in turn to introduce yourself to the committee and tell us briefly why you are here today to speak about social care.

Jim Aitken: I am retired now. My family and I have experienced care through all its guises, some good and some not so good, over the last few years. I, my brother, my wife and my sister-in-law have been care givers. Our parents have been the recipients of care from care workers. Latterly, my mum has been in a dementia care home. We have experienced the whole gamut of care and I think that I have some quite valuable contributions to make to the conversation about how we might improve some of it.

Julie Cuzen: Good morning. I am carer to my son, who is 24 and has autism and learning difficulties, and also to my mum, who has various medical conditions. During Covid and lockdown, I

also looked after my dad, who had a four-year battle with lung cancer. So, I have had various things going on. I was also a care giver and supported my sister, whom we lost the previous year to blood cancer. I am also involved with disability sport. While looking after my dad, I was involved with the carers who came in to help to look after him, so it was joint working. I have seen a lot of different aspects of working together and what can work well.

Susan Dumbleton: Good morning. I am a family carer for my daughter, who has a learning disability and is now in her 30s. I have been involved all her life in trying to organise services that are appropriate to her. That is something that I anticipate will continue for as long as I am able. I was the main family carer—not the only family carer, but the main family carer—for my late mother, who died a couple of years ago and who at the end of her life needed significant health and social care.

Ron Goldie: Good morning to you. Although I am here in Warsaw, Poland, at the moment, in—*[Inaudible.]* I am very much involved in—*[Inaudible.]*—which happened a few years ago. Since then I have been very much involved in trying to get some changes made. That is all I can say at the moment.

The Convener: Thank you very much, Ron. We will see whether we can get some improvement in the quality of your sound. Do not worry about it—we will deal with it at this end.

Steve Sinclair: Good morning. I was disabled at birth by the drug thalidomide. I have had care all my days from my parents, and for the past 20 years I have run the gamut of social care. I currently use a self-directed support package and, as for one of the previous speakers, there is good and bad. Let us hope we can get a system put in place for the benefit of all.

Dr Ann Wilson: I am a retired general practitioner. I am in receipt of direct payments and I receive support. In my household is my grandson, who is also in receipt of care because of mental health issues, so I have experience of care support being given to my grandson and to me. I have also been involved in the disability rights movement for many years, since I retired in the late 1990s. I have had experience over the years of the difficulties that support workers have in providing decent support. That is all that I have to say at the moment.

The Convener: That is excellent. Thank you very much, everybody. That gives us a good indication of everybody's expertise and background and what you know about from your own experience. We will now move on to questions and discussion. I encourage members

of the committee to enter an “R” in the chat box as and when questions occur to them. Do not wait for someone else to go first; we want to have as full a discussion as we can over the next hour or so.

Ann Wilson mentioned that disability rights is something that she has taken a great interest in. What more can be done or does more need to be done to involve the receivers of care in decisions that are made about care? If so, where should we start in doing that? If other witnesses fancy answering a question, please enter “R” in the chat box, and I will come to you as soon as I can. Ann Wilson—would you like to start off on that one?

Dr Wilson: Yes. I think that the people who provide support and the people who are in receipt of support should be involved at the very beginning of any policy changes or policy discussions on how it should be delivered. I am really keen to see the people who, at the moment, are called care workers given a more professional status. I would like them to be called support workers rather than carers. I think that people who care are the people who have an emotional link to the recipient—a daughter or a mother, for example. They are care givers, whereas people who are paid to support a person should be called something different, and I like to use the term support workers.

I know that work is going ahead to establish a national organisation, which would be a very good thing so that we can have a professional pathway for people who provide support. I would like to see that it is not called a national care service but perhaps a national care and support service or even a national support service. Immediately, you would begin to professionalise the wonderful people who give tremendous support to the people who require it to take part in normal everyday activities.

Julie Cuzen: I agree with Ann Wilson. My point is that unpaid carers, as we are known, could be recognised as a professional and skilled part of society and given a qualification, with training and monitoring, so that we are recognised along with our colleagues out there who give care. We are part of a workforce, albeit that we are unpaid, and I think that that came across during lockdown. We were there, and without our skills many of the people whom we care for—young, old, some very poorly—would have had no one to look after them. Our skills should be recognised in a professional way; there should be a professional qualification, with compliance attached to that.

The Convener: Okay. That is certainly an interesting proposition.

Susan Dumbleton: On what Ann Wilson said about the workforce being professionalised, in a sense it is, in that social services workers are

regulated and have to achieve a level of qualification in order to practise. How well that works is maybe a matter for debate, but professionalisation of the workforce exists.

I think Julie Cuzen has a really interesting idea, but it would be difficult to put into practice because of human rights issues. Perhaps not all family carers would wish to be seen as professionalisable, if that is a word. It is definitely something that is worth talking about, and I do not think that anybody would disagree that the skills that family carers have are vital to how the whole care and support situation works for people.

The Convener: Thank you very much. I will go back to Julie and put that point to her. Although I think that we all recognise the huge expertise and contribution of family carers, in a sense, part of the reason it works is because it does not require a formal qualification. Do you want to comment on that?

Julie Cuzen: Yes. I think that there should be an option. A lot of carers feel undervalued in their role. It was very relevant during Covid, when we did not have the option of going into shops at quieter times, as National Health Service workers did. People who were coming in and looking after my dad with me could access shopping at quieter times. I had to stand in a long queue and was looking after three people—my son, my mum and my dad. I was undervalued, because I did not have that option.

10:15

There were many others in the same situation, including carers who were looking after young children, which I heard about as part of Differabled Scotland—[*Inaudible*.]—as a network, there were lots of families in that situation. I feel very undervalued, so I think that people should have that choice. That is my opinion.

The Convener: You are saying that it should be a choice rather than a requirement.

Julie Cuzen: Yes, because if people want to be seen as professional, the professional qualification should have compliance attached. It would be their choice to do that.

The Convener: Thank you very much.

Steve Sinclair: I am very interested in what Julie Cuzen said. As somebody who is cared for by family and by paid carers, I am not so sure that my family members would want to get a professional qualification. After all, I help to care for my aged parents and that is not a chore; it is a choice. I feel that if you were to legislate for there being a professional qualification, there would have to be choice about whether to pursue that. I

do not think that it is something that can be imposed on people.

As for the shopping, I gave my carers a letter, because they work for me privately, and they became known by a lot of the local supermarkets and were allowed in because they were caring for me. It was a question of communication. It worked for me. I am aware of others for whom that did not work.

As somebody who is being cared for, the whole Covid thing has caused absolute mayhem for me. For the first four weeks of the pandemic, I moved my main carer into my home with me and my wife. I was lucky that I could do that, but I know of others who could not and who struggled very badly.

It is very interesting, from that perspective, to listen to the input of people who provide care and to hear the opposite perspective. For me, self-directed support has been a boon. It has given me back my freedom and my life, whereas in other aspects of care, when the local authority was organising it, it was very much a case of being told, "You'll have your breakfast at 8, your lunch at 12, your tea at 3, and you'll go to bed at 8." There was no flexibility in that. At that time, I was in my mid-40s and did not want to go to bed at 8 o'clock at night or to have my tea at 3 o'clock in the afternoon. There is a gamut of things to consider.

As for professional qualifications, I give my carers the option. I am sorry—the name of the qualification has gone out of my head. Maybe somebody else can come in and remind me what it is, but there is a qualification at higher national diploma or higher national certificate level that carers can go for. My carers have qualifications, but if they want to get the same level as local authority carers have to get now—if that is something that interests people—I am sure that provision could be made for that. I hope that I have made sense there. I lost my train of thought.

The Convener: No, that made total sense. Thank you very much. Jim Aitken has seen the matter from both sides, as a receiver and a giver of care. Do you have a view on that?

Jim Aitken: Professional qualification is an interesting idea. I suppose the only thing that concerns me a little about it is that you would have to create a whole bureaucracy to enable it to function. One of the things that I think people struggle with is that the support system—I quite like the idea of calling it a support system, rather than a care system—is complicated enough as it is. It seems not to be terribly well joined up. I would be concerned about the extra level of bureaucracy that the idea might introduce.

The Convener: I think that that is right, but it has been very interesting to have the discussion

and to see that there are different views among people who are on the front line. Emma Harper wants to come in with a question on self-directed support, which we just heard about from Steve Sinclair.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I am interested in issues relating to self-directed support. A comment in our briefing papers is that local authorities are

"unwilling to be flexible on spending of budgets: 'they made my life a misery when I asked to use £300 to buy a piece of equipment.'"

It seems that there are different options for self-directed support. One issue is that local authorities do not like SDS and put barriers in the way. I would be interested to hear what your perception of self-directed support is, and whether it works well or there are issues with it. Any feedback that you can give on self-directed support would be appreciated.

Susan Dumbleton: I will give a very personal experience. My daughter gets support from the local authority but, to the best of my knowledge, self-directed support has never been discussed with her. That is not to say that it would not be a possibility, but it has never proactively come her way. She has a very small direct payment that her family carers organised on her behalf. When we put an idea to the local authority, there was no objection to it; in fact, it was very flexible on the use of the direct payment. It was quite a creative idea, and she traded in a couple of her support hours for that very small direct payment. There was absolutely no trouble with that. The idea came from us, but that is okay, because ideas have to come from somewhere.

The barrier is the accounting for that tiny sum of money. That is because an administrative task is involved. We understand that that is public money and that it has to be accounted for, but the way that that is done means that it is a bureaucratic process, not a human process. I do not think that someone with a learning disability would be able to understand the questions that are asked and the way that the accounting is done.

From my experience, there are barriers other than the ideas around self-directed support that need to be looked at.

Steve Sinclair: I was on local authority support and wanted to transfer to self-directed support. It was like turkeys voting for Christmas. The issue was not so much with the carers but the people in the office. If I moved, there would be a client fewer and less budget. To be fair, that was 15 years ago. Moving areas has been a lot easier since then.

As I said earlier, self-directed support has given me my life back. The carers in North Lanarkshire went above and beyond, but their hands were tied

by what they were allowed to do, the jobs that they were given, and the times that they were given to do them in. The service was heavily subscribed.

Self-directed support has given me the freedom to live my life again. Incidentally, since I started to get self-directed support, I have got married—not to one of my carers, but to somebody whom I met. I have lived in three different local authority areas since I was awarded it, and each of them has a different way of running it. The lady who has just spoken mentioned the bureaucracy and having to fill in the forms. We are well aware that we have to account for the money because it is public money. I am also in receipt of independent living fund money, which is a godsend. I am grateful that Scotland kept that fund after England abolished it.

My question is: why can local authorities not adopt an agreed system Scotland-wide to manage self-directed support in a more simplified manner, in which we still account for how we spend the money on carers? That would be fairly simple because, if a person has a paid carer, they have somebody somewhere doing the wage slips, working on what they are paying and so on. Various bodies do that; I prefer to employ an accountant. People have records of where they have spent money and a bank account that the money goes into, so they can see what is coming out. It would be easy to provide bank statements every three months and a copy of wage slips. Why can Scotland as a country not provide a one-size-fits-all service that each local authority has to abide by or put in a system that is similar to that which is used by the independent living fund, in which a central body deals with self-directed support payments, and therefore make it easier for people to manage budgets?

The approach was very straightforward in one area. When I moved to the Borders, there was a different system that took a bit of getting used to. I have now moved to North Ayrshire, where I feel at times that I need to be a Mensa candidate just to deal with justifying where the money goes. I keep saying, "I have money in it. I have more than I should have, and I need a new wheelchair," for example. It is like trying to crack open a walnut with a toothpick—it is not that easy. I get that it is public money, but can we not just have one system and one body that oversees it so that people know what is expected from them and public money is protected?

The Convener: Again, that is a very interesting and worthwhile point.

Julie Cuzen: I have examples from different local authorities, one of which involves my son, who receives self-directed support. We approached the local social work department because he wanted to make a slight change. We asked for the senior social worker to phone back

to discuss what he wanted to change and what he wanted to do. Without even having a discussion, we spoke to the duty worker, who went off. They called back, and the answer was a point blank no. My son cannot understand why a proper consultation and conversation in which his views were listened to did not take place. That is how it should be. He should be heard, and there should be a proper conversation. It feels to him that he is dismissed, and I agree with him.

Communication is key. Ryan, who is autistic, always says that it is about transparency, information and communication. He knows that, if all that works together—even if the outcome is that they do not change anything—he, as a young person with a disability, will have been heard, and that is fine.

The other example involves a young man whom I work with. I work as a personal trainer, and I work outdoors with him. Three years ago, he was given self-directed support, and he has only just discovered that. He left school and went to a garden centre. His mum understood that the social worker had just found a place for him, because he has learning disabilities and college was not going to be an option. I said to her, "I think that there is self-directed support going on in the background here," because, all of a sudden, he was asked to pay a rather large amount of money. That amount went from £10 a week to £160 a month.

He went to Citizens Advice Scotland, which said that he could not afford to pay that, but he had to pay it. I asked his mum to get in touch, and we recently discovered that the social worker has left. We now have a contract, and he has self-directed support. She had never seen a contract, even though she applied for guardianship when he was leaving. She has seen that only this week. It turns out that he has that option. All the support stopped when lockdown happened. She is now asking whether that can be switched to a different option. However, that young man went through the whole transition without his mum knowing about that, even though he was in an additional support needs school and he has a learning disability. Obviously, he did not understand, and his parent had no knowledge of a self-directed support assessment taking place.

The other example involves a young lady who was given self-directed support to move into her own flat. She needed help with cooking and planning. Covid struck, everything was taken away overnight, and she was left with no support at all. Her parents had to step in. Two months down the line, she had no support. She could not operate Zoom, and she had no communication whatsoever. People pay money towards the self-directed support package, so surely it is not just the responsibility of the family to step in. The

service that provides the support should have plans in place for emergencies to ensure that the young person is not left isolated with no support, especially when it comes to food, shopping, making meals and communication with the outside world.

There has to be joined-up working to ensure that such cases do not happen. We have to plan for that.

10:30

The Convener: Absolutely. Thanks very much for some very good examples.

Are there examples from Ron Goldie's experience?

Ron Goldie: I will go back a few years. I lived in Germany for 25 years. Unfortunately, I lost my wife over there in April 2010, and I made the spontaneous decision to come back home. When I came home, I was, obviously, distraught. I had just lost my wife, I was in a bad way, and I drove around the country. I stayed with my family, which was uncomfortable, to say the least. I really did not know where I should go to get help.

One evening, I sat in my car and decided that I should either throw myself off the nearest bridge or get help. I decided on the latter and drove myself to the Royal Edinburgh hospital, where I was told, "This is not the place for you. I'm sorry." It turned me away. I said, "Where am I supposed to go then?" I was told, "Try the Samaritans." I refused to go and said, "Look, I need help here. Someone should be available to help me." Eventually, a couple of people came in. I assumed that they were psychiatric nurses. They had a chat with me, and they said, "I tell you what. You go home, and we will come in the morning and have a chat with you." That never happened, and I was left to my own devices.

Eventually, I moved house. I managed to get an apartment on my own. My doctor found me in a state. Somehow or other, they managed to get in the door. I had overdosed and things like that, and I was in a bad way. It was only then that I was offered any counselling.

Since then, I have campaigned for the rights of people with mental health issues. I work closely with CAPS Independent Advocacy and various other organisations. With CAPS Independent Advocacy, we were asked to formulate a report, and I was invited to join the patients council at the Royal Edinburgh hospital. I went there, and we had a chat with people from that hospital. The stories that they told me were horrendous. I thought to myself that those things should not be going on in this day and age.

I went home after handing over what I could to CAPS Independent Advocacy. A couple of days later, I got a phone call from the chairman of the patients council at the Royal Edinburgh hospital, who said, "We don't want you to come back." I said, "Why is that?" He said, "You ask too many questions." I said, "You are kidding me." He said, "No. I have been told that you ask too many questions." I said, "No, you are wrong. The patients volunteered the information to me. I did not have to ask anything."

Since then, I have made it my business to look into such things in a peer-support role. I have looked at various aspects and chatted to people who have been admitted or not admitted to the Royal Edinburgh hospital. Apparently, such things are still going on. Why are they still going on?

The Parliament should at least look into those allegations and not just brush them under the carpet as though those things did not happen. It is said that there is a lot of financial help going into the mental health system. Where is it going? No one knows.

I spoke to a night nurse who worked in the Royal Edinburgh hospital and was told that people sedate the patients so that they can have a quiet night. Should that be going on in this day and age for people with mental health issues? Scotland has the highest rate of male suicide in western Europe. That is because they cannot get the treatment that they ask for.

The Convener: That is a really important point and it is certainly something that we will come back to.

Ann Wilson wants to say something on the subject of self-directed support.

Dr Wilson: I have been listening to all the other people who have given you examples, and I am aware that things vary considerably from one local authority to the next as to how the deliverers of self-directed support—the social work departments—handle it.

I was involved in the training of social workers in Dumfries and Galloway when the change to self-directed support came about with the Social Care (Self-directed Support) (Scotland) Act 2013, and I was well aware that a lot of the social workers did not get it. They really did not understand the concept of it being a person-centred service, and they were trying their best to continue to manage the client.

I do not know how we can deal with that, but we have to level the playing field somehow, so that the delivery of self-directed support across Scotland is fair and equitable. Maybe it should not be social work departments that deal with it. If we

have a national care and support service, maybe that should deal with the self-directed support.

The other thing is that social work departments are under terrific strain. That is certainly the case in my area. With the financial cutbacks, there are fewer and fewer social workers on the ground, so to speak, and it just impossible to get hold of a social worker. We called for some help for my grandson from the mental health department and it was much better, but people can wait for ever even to speak to a social worker. That should not be the case. People should be able to get a response from their social worker. I do not even know who mine is. They keep changing. I think that, because of the cutbacks, not enough are being employed. It comes down to money—to the finance.

The Convener: That is often true—yes.

Dr Wilson: Also, support workers are not adequately remunerated. They need a huge hike in salary.

The Convener: We have certainly heard other evidence to that effect.

A number of people want to contribute. I will go back to Emma Harper first.

Emma Harper: It is interesting to hear that different local authorities manage self-directed support in different ways. We can explore that. It is also interesting to hear Dr Wilson's comments about access to social workers. I am curious about whether it has become worse during Covid or whether it had got worse even before the pandemic.

The Convener: Susan Dumbleton is keen to respond to that, but before I bring her in, I will bring in Jim Aitken.

Jim Aitken: I think that the point touches on a wider issue to do with social care more generally. It seems to be something of a postcode lottery, because the level of care and support that people get varies quite significantly between one local authority and another. There is a bit of a win to be had here if we can somehow bring all the resources together in one place so that they can be properly managed and controlled. In that way, whether people live in Shetland or in Edinburgh, they will know that they will get the same level of support.

The Convener: Absolutely.

Susan Dumbleton: My answer to Emma Harper's question about whether it has become worse during the Covid pandemic has to be yes. Everything has been worse during Covid and the lockdowns.

My comment relates to what Jim Aitken has just said. This is a lot wider than just care and support;

it is about our social organisations and the way that we approach support for people who need a wee bit of extra help. It is not right to put it all on to social work departments, social workers or mental health nurses.

We can use the pandemic to illustrate that, because it has so often been the informal structures that have supported people's lives, and not the formal, paid-for care and support, vital though that is. The other things that go on in society that also help people to live full and fulfilled lives are so important, but so many of them have just gone and they may never come back. That is a huge issue, not just for the formal structures—*[Inaudible.]*—social capital in Scotland is strengthened and increased.

It is important that we try to support those informal structures, and not just families—again, vital though they are. Goodness me—we all know how important family support is, and that things just would not operate if it was not there. The same applies to paid, formal structures. However, it is the other things that have supported people—the opportunities, the wee bits of voluntary work and whatever it is that people's social networks consist of—and so many of them have gone. I do not know whether any research has been done on that. I think it is really important.

Julie Cuzen: We are looking at the future, and it is not about reinventing; it is about looking at the good practice that exists and building on that. The ILF, which Steve Sinclair mentioned, is person centred and patient centred. I had a good experience when my dad came out of hospital. There were great examples there, and the support was built around what his needs were. As things changed, he went from palliative to end-of-life care, and I was able to pick up the phone and get a social worker on the end of the line. From one day to the next and then into the following week, I was saying, "This has changed", and things were put in place very quickly.

Good practice should be streamlined across all local authorities up and down the country. It should not be a postcode lottery. We need to work on having good practice across the country and having it streamlined. If something can be a success in one area, it can be a success across the country, and that is what we need to build on. It works for the independent living fund, and I also see it work with the transitions fund for young people. They are asked what will work for them, and the support evolves, because the service listens to the feedback from the young people, parents and carers.

Those services evolve, adapt and change, and that is the future. Everybody working together and collaborating is the future of social care.

10:45

The Convener: A number of MSP colleagues have questions. Sandra White has just reminded me she has a question about personal protective equipment.

Sandra White (Glasgow Kelvin) (SNP): Thank you so much for what you have said already—it has been very interesting. When I was looking through the information that you sent us, I noticed that three of you particularly mentioned difficulties with obtaining PPE. Will you elaborate on why you had difficulties and how you managed to get it?

The Convener: Steve, I think that you mentioned that, and Ann Wilson also wants to comment.

Steve Sinclair: PPE was a problem initially. Everybody and their dog was buying it, which made it difficult for those who needed it. Eventually, the local authority stepped in and gave us access to its stock. It handed out PPE to its home care team, although it only did that once, probably because other streams opened up.

The issue that I have had is that, although PPE can be paid for from your self-directed support budget—you need a receipt, quite rightly—it gets questioned every time. I buy my PPE in bulk and the cost is £40 a month or whatever for all the different bits and pieces that are needed, but they go through it every time and ask, “What’s that for?” and “Where’s the receipt?” even though it is, give or take, always the same amount.

It was difficult to access PPE because everybody was getting it. That seems to have been worked through and it is now more freely available. I am showered by carers, who need PPE, and it cannot be reused. That was difficult. It has resolved itself, but initially it was an absolute nightmare.

The Convener: That is interesting.

Dr Wilson: Obtaining PPE was a complete disaster. People did not know where to get it, whether they were responsible for it or the support worker was responsible for it, whether they had to pay for it or whether they could receive it for free from the social work department. If they paid for it, did it come out of their direct payment? If so, was their direct payment to be increased? There was no guidance whatsoever.

When people finally managed to speak to a social worker, they would get a different response each time. The responses varied from, “Come and get some” to, “You have to buy it yourself”. They obviously did not know what they were supposed to be doing about it, and we did not know what we were supposed to be doing, either.

The Convener: I think that Julie Cuzen is the other person who mentioned PPE in advance of the meeting.

Julie Cuzen: Initially, we did not have any PPE, either. We sourced our own. My partner, who is in the whisky industry, turned into a hand-sanitiser producer and he managed to source PPE. About a month down the line, we were contacted and told that we could have some, but by then we had bought our own, which allowed Ryan to continue to work with his personal assistant. Otherwise, we would not have been able to continue that contact, which is vital for Ryan.

The Convener: Those are interesting experiences. David Stewart has a question.

David Stewart (Highlands and Islands) (Lab): I thank the witnesses for their really important evidence. I want to touch on a couple of points that Jim Aitken and Julie Cuzen made about how we should fund social care in the future. Jim mentioned the postcode lottery problem of different local authority areas having different approaches. We all know about the increase in demand because of the growth in the number of people who are over 80 and the growth in dementia and diabetes.

How should we fund social care in the long term, bearing in mind that, since 2013, we have seen an increase of about 7 per cent in the NHS budget while we have seen a cut, according to Professor David Bell’s figures, of about 13 per cent in funding? Is it time that we had a different model? Should we look at hypothecation—in other words, raising tax specifically for social care? How do we square the circle? Demands are going up, but budgets are going down in some aspects of social care funding.

Jim Aitken: This is something that we have direct experience of. It is a really interesting question. There is no easy answer to it, but I suppose that the context is important. The financial cliff edge that exists between care in the home and care in a care home is astronomical—it is eye watering.

I will use my mum as an example. This is a kind of everyman story, but it is also very personal to us. My mum, like my dad, has been really quite poorly in later life. My dad was physically very poorly and he was in poor mental health. My mum suffers from dementia. Initially, the care was provided primarily by my brother, because he lived quite close to them, but also by me.

As their health deteriorated, we approached the local authority to get some help with care in the home, and it was fantastic. I have nothing but praise for it. My dad passed away, though, and it is no exaggeration to say my poor wee mum literally fell off a cliff edge mentally. All the

professionals who were looking after her said that she reached the point where she needed 100 per cent professional care all the time, and the only real option that we had was to put her into a care home.

When she was getting care at home, it was in effect free at the point of delivery. When she went into a care home, the cost went up overnight from zero to £42,000 a year. My wee mum's combined pensions are £22,000. There is now a gap of about £23,000 between what she gets in income and what she has to pay out. We had to sell the home to pay for that, and within four years, probably, all her life savings, apart from a small amount, will be wiped out. We get some support through social care. It is about £190 a month, which pays for one day's care.

That is the context within which this exists. As I said, that story is not unique to me, but it feels very personal to us. The thing that I find particularly troubling is that, when my mum was working, she worked for the NHS. She was a nurse. She started off as an enrolled nurse, and by the end of her career she was the senior nursing officer in charge of the Glasgow Royal infirmary. All her life, she provided care for people, and it was free at the point of delivery. The one time in my mum's life when she needs professional help that is beyond the ability of my brother and me to provide and she cannot have care at home because she is so poorly, she is having to pay all that money.

I am deeply troubled by all of that. It seems deeply unfair. I accept that she probably has to make a contribution towards that care, but it just feels like she is paying for everybody.

The question of how we fund care is the \$64 squillion question, is it not? I think that we are going to have to make some hard choices, as a society. I think that a taxation component will have to come in. Do I have the answer to that? I do not—I wish that I did. We are going to have to make some hard choices, and we will have to have an open conversation as a society about those choices. That is the context. I think that it is a key issue. As I said, that is an everyman story as well. It is not unique to us.

The Convener: It is not unique, but it is very good for us to get such a personal example of something that we are aware of more broadly.

Steve Sinclair: As Jim Aitken said, the funding side of things is the \$64 million question. I am thinking to myself, "£42,000 a year for a care home", and I am doing the maths for a team of carers in a home. There must be a better way to fund it.

It all has to be about choice. Some people may prefer a care home with the costs that are

involved, but others may prefer to stay in their own home. My father is 89 and he has vascular dementia. He is being cared for at home with a combination of family and carers. He may have needed to go into a care home this year, but because of Covid and things we have done our best to prevent that.

From my perspective, it seems that a senior nursing officer in Glasgow Royal infirmary worked hard all her days, but what she worked for, for her and her family, has been taken away, whereas somebody who perhaps has not made that contribution to society has been looked after. Obviously, it is correct to look after our citizens, but things need to be more level. That is not somebody who has won the lottery and has £10 million and is paying a higher rate of tax. It is somebody who worked in a job and is now being taxed again to pay for their care. It just does not sit well with me.

How should we fund self-directed support? When I first got it, I was living in North Lanarkshire, and its budget at that time was something like £25 million a year to provide the service. If everybody had gone to self-directed support, the cost would have halved. We have to look at how the care is provided. Choice is important. As I mentioned at the start of our conversation, I feel that a national body would be more cost effective.

It would be interesting to compare the costs of running the independent living fund and self-directed support to see what streamlining savings could be made by having a single body. It is a postcode lottery, because each local authority budgets in a different way. It is important that those of us who are vulnerable and less able are looked after by society. There has to be a way to balance the books a little bit better, not just for social care, but for all aspects of public money.

Julie Cuzen: When it comes down to cost, at the moment Ryan needs some help, because he is not as independent as some of his peers in society. We always had a vision that, one day, he might gain more independence, and that is what we keep striving and working towards. We continue to pay into society and to support him. We hope that what we do helps to fund the support that Ryan and others receive.

My dad died with dignity and respect, and that was because of the social care system that we have. Unfortunately, my sister did not have the same quality of care. She did not have social care, because her illness was quite short. She did not have that support and she did not have dignity and respect. She received that in her last days, when she went to a hospice, but she did not have that in our social care system. Sadly, it let her down very badly. I do not think that we can put a cost on that.

Having dignity and respect is so important. As a nation, we must work together to find that money.

People who have disabilities and additional support needs and are the most vulnerable in society deserve to be treated with equality, respect and dignity. The cost of that goes way beyond finding those pennies. Yes, we should find those pennies; we should not be putting that on them. They are the most important people to protect in society, especially during a pandemic.

11:00

Susan Dumbleton: As I said earlier, this goes beyond health and social care, social work and our formal structures. I think that Jim Aitken is right: we need to have a conversation that involves everyone. We need to make choices about the way that we fund things. The issue is certainly about taxation. There is no way that we can provide the services that we aspire to if we do not raise the taxes to do it. That is uncomfortable. Most politicians do not like that sort of discussion, and I understand why. In fact, nobody likes it, but that is how we can raise significant money, and I think we would all agree that social care is woefully underfunded in all senses.

If that is what, as a society, we aspire to do, we need to bite the bullet and get on and do it. We have been having these conversations for a long time. A Martian who came to Scotland might conclude that this is the situation that people want and accept, but that is not what the committee is hearing today. We just need to get on and do it.

The Convener: Thank you very much. I think that Dr Wilson also wants to contribute on this point.

Dr Wilson: I agree whole-heartedly with what Sue Dumbleton said, especially the point about dignity and respect and the point about biting the bullet and getting on and doing it.

We were talking about adequate remuneration for support workers. If workers are adequately remunerated, they will be taxed. It is a circular thing: you remunerate people correctly and they pay back into the system through their taxes. We need to have the conversation about what sort of society we are in Scotland. Are we a social society that looks after everybody or are we not? Are we an every-man-for-himself type of society? I think that we are not; I think that we are a more social society. If that means that we have to consider higher taxes, so be it.

The Convener: Thank you very much. A couple of colleagues have questions to put to the witnesses.

Brian Whittle (South Scotland) (Con): I thank all the witnesses for their very insightful points. I

will go back a bit, for which I apologise, but Sue Dumbleton said a couple of things that popped a few lights on in my head. One of them was about the opportunities—[Inaudible.]—part of society. We are talking about the need to raise funds—whether through taxation or whatever—so that we can treat everyone in society with the dignity and respect that they deserve. The flipside of that—which the committee has discussed previously—is how much we pay for things.

What do the witnesses think about the idea of including access to public transport or community facilities as part of the remuneration programme so that all of society can take part in community activities?

The Convener: We will start with Sue Dumbleton, given that Brian Whittle mentioned that she had commented on funding. Anyone else who would like to contribute should feel free to indicate that in the chat box.

Susan Dumbleton: I am sorry, Brian, but your sound dropped out at the vital moment when you were reflecting on what I had said. I think that your point was about informal opportunities.

Brian Whittle: That is right.

Susan Dumbleton: Thank you.

I will bring this back to personal experience. In the past, my daughter has had many social opportunities that have not been part of her formally assessed and paid-for support services; they are opportunities that she has had help to access or has been able to access for herself. What those opportunities are does not really matter, because they would be different for everyone. The point that I was making was that many of those opportunities have gone because of the Covid restrictions; for a lot of other people, they were never there. I suppose that my daughter was lucky, in the sense that her capacities and interests matched some local opportunities, but I recognise that many people do not have any such opportunities.

The short answer is that good, decent, dignified, respectful social care depends on a lot more than paid-for, assessed, regulated services; it must do, because it is about being part of society. Ann Wilson made the point that that is the kind of society that we aspire to for everyone. We should take any chances that exist to strengthen those social opportunities, because they provide so many benefits—the number is probably uncountable—to people from being part of their community. Those opportunities are extremely important, but they are intangible until they have gone. Many of them have now gone, and we can see the effects of that. Free public transport would be absolutely brilliant.

I do not know whether that answers Brian Whittle's question.

The Convener: I am sure that it is a good part of the answer. We will hear from Julie Cuzen and then from Ann Wilson.

Julie Cuzen: I agree with the point about free access to public transport. I know from a lot of our members that having the finances for access to transport to get to training events for disability sport and access to venues for training is and always has been a problem for young people. Regular training can put them on pathways to competitions for entry to the special Olympics; in some cases, it can put them on more elite pathways. Therefore, free access to public transport is a great idea.

Dr Wilson: Access in all its forms is a huge issue. What about people who, with support, would like to be employed but cannot access the office, for example? Having free bus transport is very good, but what if you cannot get on the bus? Not all buses are accessible for wheelchair users, and when they are accessible, they take only one wheelchair user at a time.

I have been in the situation in which I have not been able to travel because there was already a wheelchair user ahead of me in the queue and they got the one and only place. That cannot be right. Access to and within the built environment is a huge issue. The situation is improving gradually, but it is still a long way from what it should be. Access to rail travel is improving, but it is still not good. A wheelchair user is treated more like luggage than a person.

The Convener: Thank you very much. Willie Rennie has a question.

Willie Rennie (North East Fife) (LD): I am very sympathetic to the argument around spending and taxation, which is at the heart of the discussion, but social care is probably the interface between the role of the state and personal responsibility and personal freedom. Where do the witnesses think the threshold lies between the state picking up responsibility for the cost of something and the responsibility lying with the individual? Is it the case that if somebody needs care, all the associated costs should be borne by the state, or does the individual have some responsibility?

I do not know whether the witnesses have a view on that question. It is a tricky one, but I would appreciate any thoughts that they might have about it.

The Convener: It is a big question. Would Jim Aitken like to kick off?

Jim Aitken: We can contrast what happens to somebody with cancer, for whom all the costs are covered while they are in hospital, with what

happens when somebody who is suffering from dementia goes into care—hardly any of the costs are covered. That seems quite anomalous to me.

I am personalising things again, but that is the only way that I can talk about the issue. I accept that my mum should make some kind of contribution to her long-term care, but—this is where I struggle—the medical professionals who looked after her said that she needed 100 per cent professional care all the time. I think that there has to be a point between the state doing everything and the person doing everything, with both making a contribution.

You could argue that people have already made that contribution, because they have paid their taxes and their national insurance contributions all their lives—that is where their contribution comes in—so the money should be there to help with their care later on. It is the \$64 million question. I tend to the view that if a medical professional says that somebody needs professional medical care 100 per cent of the time, which is the position that we were in, most of that cost should be picked up by the state.

Susan Dumbleton: It is a huge question and a good one, because it makes us all think about our personal responsibilities.

I come back to what I said earlier—I have said this about three times now—which is that the contribution of the state does not have to just be in the form of services. I think that it would be of some benefit if there was a way of the state strengthening the third sector or providing things at a much less formal, community level. Many of us are very happy to contribute at a community level to strengthen our society, but it would be very helpful if the state could make some contribution to that effort, in addition to all the other contributions that it has to make.

The Convener: Does any other member have a question? I know that David Stewart flagged up that he had a question around the use of technology. There he is, on cue.

11:15

David Stewart: Dr Wilson touched on my general question. It is very important to look at technology to help towards care in the future. For example, in the Highlands, our local health board and Albyn Housing Society have developed the concept of fit homes, which are barrier-free housing with state-of-the-art aids and adaptations. The homes have sensors that allow health professionals to detect whether there is any movement. That follows the tragic case of an individual in our area who was dead for over a year before that was picked up. The concept of fit homes is really important. Barrier-free housing

means that we vary building regulations so that houses are built with, for example, wheelchair use in mind, which I think was Dr Wilson's point.

Could we develop fit homes across Scotland? My experience from many years of working in social work is that, in my day—the 1980s—it was sometimes easier to get an individual into a care home than to get aids and adaptations in their house, which seemed a crazy way to do things. I want to develop the concept of fit homes as best practice, and I am interested in the witnesses' view of that.

Jim Aitken: That is really interesting. Speaking once again from personal experience, I have been to America quite a few times and one thing that I noticed is that light switches in American houses are universally at wheelchair level, so you do not have to reach up to switch on a light. That is a very simple adaptation that we could easily make. Little things like that can make a huge difference. Another one is making sure that, when houses are designed, it is universal that the doors are wide enough to cope with wheelchairs.

The Convener: Yes. The point is to make that the rule, rather than the exception.

Jim Aitken: Yes.

Steve Sinclair: I am having a wry smile about aids and adaptations to houses. I am lucky enough to own my home, so I have the house sympathetically adapted for my use. It is a relatively new build and things have been done for me and my wheelchair. I have just had a vision that, instead of my carer, who has worked for me for 15 years, helping me to get in and out of bed and up and ready, in will come Senga the robot—that just tickles my sense of humour. As long as we have the human aspect and human interactions as well, we should have whatever aids and adaptations would help to improve safety. I am sorry about my sense of humour, but I can just see Senga the robot coming in and lifting me out of bed and showering me and so on. Aids and adaptations should be more freely available.

The Convener: We might invite Senga to come and give evidence next week, but not just yet.

Dr Wilson: I have had quite a few adaptations done in my house, all in the early noughties. For instance, I had a lift put in, the cost of which was shared between me and social work, and it has been a huge advantage to me. I agree wholeheartedly that we should look at the building regulations from now on. All new builds should be built to what are called visitability standards, with a toilet available downstairs and passageways that are wide enough for wheelchairs. Access to the house should be level, at least to one entrance. I have seen new builds being built without level access, which seems so silly.

As we are talking about new builds, as a quick aside—this is nothing to do with health and social care—should there not be a regulation that all new builds should have solar panels?

The Convener: That is a very good question, but perhaps not one for now.

Dr Wilson: Yes, but if we are talking about new buildings, it is one more bit.

The Convener: That is absolutely a fair point. Thank you.

We have one last question, which is from Emma Harper.

Emma Harper: I want to pick up on Julie Cuzen's point about training. Moving and handling training is something that I have come across in casework. People who provide support or care need to be able to protect their health and wellbeing and prevent back injuries, for example, because if a carer ends up with a sore back, that puts everybody in jeopardy. I would be interested to hear about what moving and handling training or other training is provided.

The Convener: Julie Cuzen will come back in on that and I know that Jim Aitken also wants to come back in on something.

Julie Cuzen: When my father moved to palliative care and then end of life care, we were in the unfortunate position of Covid coming into our lives, so there was no training. I had to call on my niece, who formerly worked in a care home, to come in and train us, because we had no other training. My mum, who is 77 and has complex medical conditions, was not fit to move and handle my dad, so my niece gave me a training session on how to move and handle him safely.

That was the training that I had. Otherwise, I would not have been able to do what I did and care for my dad through the night. We had carers coming in, but they could come in only at certain times. I had to be there most of the time with my dad, and I had to rely on a family member to come to the house and train me.

Jim Aitken: On technological solutions, in a previous life, I worked for Her Majesty's Revenue and Customs, and one thing that we did was to work with various agencies and stakeholders to put together a system called once and done, for people whose loved ones had passed away. Previously, people would have to tell the Department of Health and Social Care, the Department of Social Security, HMRC and other organisations individually that their loved one had passed away. Now, they go in and tell just one person, and that person tells everybody else.

There is a bit of a win in pulling together all the information and documentation on social care into

one website. You would need to get all the stakeholders involved to identify the available physical and financial support. People could then access that perhaps through a Scottish Government website, but the same information could also be accessed through local government websites, so that everybody could see the same thing and do the same thing. It is a fairly easy win.

Having been involved in the design of once and done and then unfortunately having had to use it, I know that it works. Pulling together all the information could benefit people and take away some of the stress and strain of deciding who to deal with and who can help. People would just need to go to one source, and the infrastructure would sit behind that to pull it all together.

Steve Sinclair: Training for self-directed support from professional carers can be covered by people's self-directed support budget. Carers can attend the same training on moving and handling that somebody who works for the local social work department gets. It is available.

That goes back to my earlier point about a one-size-fits-all body. Jim Aitken is right that we need a one-size-fits-all website, with a one-size-fits-all overseeing body. I am lucky, as I have had the same paid carers for quite some time. Their training is refreshed every two or three years at no cost to me, but moving and handling is different for different types of disability. In my community, some people have particular disabilities that mean that even carers with proper moving and handling training would not work with them. Folk who provide care for people at home need access to training to help them to provide care in the best possible manner. That goes back to my original point that, if we had one body overseeing the whole gamut of issues—including budget and websites—the process would be easier.

The Convener: I thank everyone for their evidence. I will ask each of the witnesses one final question. It is a hard question, because it is asking you to put in a single sentence the one thing that you would most like to change to improve social care in Scotland. What would be the one thing that would make the biggest difference? Dr Wilson, what is the one thing that you would want to see changed to make things better?

Dr Wilson: That is not fair. I have not had time to think. [*Laughter.*]

The Convener: I can come back to you if you like.

Dr Wilson: It is okay. One thing that I would like to see is care workers being called support workers and having the respect that they deserve through a professional pathway with adequate remuneration.

Steve Sinclair: One sentence is difficult for me. It is about standards—standards of care, standards of service and standards of budgeting—or, in other words, respect.

The Convener: That is indeed succinct. If you think that one sentence is difficult for you, remember that you are talking to politicians—we have the same problem.

Ron Goldie: I would like more to be done about the care of people with mental health issues. I feel that not enough is being done at present, and I would like that to be addressed.

Susan Dumbleton: I would like to see creativity being included in any assessment of people's support needs. There is an overreliance on what we have done before. Building on that, I would like to see the social services profession broadened to include more creative—[*Inaudible.*]

The Convener: More creativity is the bottom line there.

Julie Cuzen: I would like to see a person-centred approach up and down the country, and I would like it to follow the example of ILF Scotland's independent living fund and transition fund, which take proper person-centred approaches. That should be rolled out up and down the country and streamlined throughout our local authorities.

The Convener: The last word will be from Jim Aitken.

Jim Aitken: I would like things to be more joined up and, ultimately, I would like accessibility, fairness, affordability and simplicity.

The Convener: Excellent—thank you all very much. I thank all the witnesses for a fantastic evidence session. I was particularly impressed by the short, sharp points at the end, where you all did exactly what I hoped you would do. Beyond that, I was impressed by the detail of some of your earlier answers, which was great from our point of view and will help to inform our inquiry.

You will perhaps know that we have another session next week, and you might be able to follow that on the Scottish Parliament broadcasting system. We will be hearing from some of those involved in the provision of care.

I now suspend the meeting for five minutes, so I ask members not to go away. We will resume in five minutes, at 11.35, when we will hear from the cabinet secretary.

11:30

Meeting suspended.

11:35

On resuming—

Subordinate Legislation

**Health Protection (Coronavirus)
(International Travel) (Scotland)
Amendment (No 20) Regulations 2020 (SSI
2020/343)**

**Health Protection (Coronavirus)
(International Travel) (Scotland)
Amendment (No 21) Regulations 2020 (SSI
2020/354)**

**Health Protection (Coronavirus)
(International Travel) (Scotland)
Amendment (No 22) Regulations 2020 (SSI
2020/358)**

The Convener: Welcome back to this meeting of the Health and Sport Committee. The second agenda item is consideration of subordinate legislation. Like the instruments that we have considered in previous weeks, the three instruments that we are considering have been laid under the Public Health etc (Scotland) Act 2008 in relation to international travel and coronavirus. They are made affirmative instruments; in other words, the affirmative procedure did not apply to the instruments because they were made urgently, but they are now with our committee for consideration under section 122(7) of the 2008 act.

We will have an evidence session with the Cabinet Secretary for Justice and his officials on the instruments that we are considering, which are the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 20) Regulations 2020, which removed Cyprus and Lithuania from the exempt country list; the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 21) Regulations 2020, which removed Denmark, Germany and Sweden from the exempt country list; and the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 22) Regulations 2020, which make further amendments in relation to Denmark, requiring a particular level and longer period of isolation for those arriving from that country.

To answer our questions on the regulations prior to our debate on them, I welcome to the committee Humza Yousaf, the Cabinet Secretary for Justice, who is accompanied once again by Anita Popplestone, the head of police complaints and scrutiny in the police division; Craig Thomson, who is the border measures review team leader;

and Victoria Calpin, who is performance team lead for test and protect performance and delivery. I invite any members who have questions for the cabinet secretary or his officials to indicate by typing “R” in the chat box in the usual way.

Cabinet secretary, I ask—as I do fairly frequently—for an update on the level of contacts made by those who are required to isolate under these and previous regulations.

The Cabinet Secretary for Justice (Humza Yousaf): Good morning, convener and committee members. I hope that you are all keeping well and keeping safe.

The latest figures were published last Wednesday. In the week ending 8 November, 12,031 people who arrived in Scotland were required to quarantine. The number of people contacted by the national centre was 2,964. I am pleased that we are exceeding the target of 2,000 that we committed to. A full breakdown of that report from last Wednesday is available and, of course, tomorrow’s figures will be the most up to date for the week that has just passed.

The Convener: Thank you very much.

Willie Rennie: I am interested in what will happen over the festive season. What intelligence do you have on travel by students and holidaymakers? Do you have any intelligence from airlines and travel agents about whether there has been an increase in bookings? Will you increase the capacity for spot checking to make sure that we keep on top of the situation?

Humza Yousaf: Thank you for a very important question about something that was discussed at last week’s four-nations call. The general consensus—and of course this will be understandable—is that we will not see the same numbers travelling to catch some winter sun as we have seen in the festive break in previous years, but clearly there will be greater numbers of people who will travel, including students, as Willie Rennie says.

That is why I have a bit of concern around any piloting of a different airport testing regime. Members of the committee have asked me about looking at a test and release type of scheme at airports. We are exploring that through the global travel task force, but there has been some robust debate around whether that should happen before or after the winter break. My opinion is that it probably should be after rather than before.

The 2,000 checks that we committed to are giving us a good sample size. I am more than happy to enter into discussions with Public Health Scotland about whether we need to increase that capacity. My concern—I will be very frank about this—is that, at the moment, resources will be

rightly and understandably focused on the upsurge of symptomatic cases across the country. It does not seem to be a good use of resource to divert resource from checking those contacts to checking up on people who largely will be asymptomatic international travellers. There is no intention to increase the number of contacts being made at this stage, but of course we keep that under review.

Willie Rennie: [*Inaudible.*—about why you would not do that testing before Christmas, even under a pilot. What is the logic in delaying it until after Christmas, especially if you will not be increasing the numbers of spot checks?

Humza Yousaf: I have not made a firm decision about it, so I will not say that we definitely will not do some sort of airport testing. We have to grapple with numerous questions. The clinicians' view, which I looked at last night, is that it might not be a wise move to test a new system before the winter break, when, although it will not be as great as it has been in previous years, the number of passengers will still be greater than it currently is. That is particularly because that type of testing would rely on private capacity—we do not want NHS testing capacity to be used for it.

I am not averse to doing it; I just have some concerns about whether the proposed system is robust. We will test it and ask the questions that need to be asked, and if we are satisfied with the answers, a different airport testing regime could be implemented before the festive break, but it is important to get the balance right. We must be satisfied that we are not piloting a new system that could have some teething problems right at the time when we will have a greater number of people travelling.

Emma Harper: Good morning, cabinet secretary. Picking up on Willie Rennie's comment about testing, if any new testing regime is implemented, whether it was done by the private sector or not, it would have to be robust and evidence based. We would not want to see any false positives that might make people proceed in a way that would change their behaviour compared with if they had a true positive. Would it be a valuable statement to say that we need to make sure that any regime that is tested or piloted needs to be robust and secure?

Humza Yousaf: In short, yes. That is why the proposal will probably not include an immediate test on arrival, although that is something that is worth considering. It may be that people will be tested on day 7 or day 8, for example, and that, therefore, the quarantine period would be slightly shortened, if it is safe to do so, but the clinicians are still going through the details of what the global travel task force is looking at. We have not yet had the paper in all its detail. We are expecting

it imminently. The task force will probably present its paper next week and, as we always do, we will try to work together as four nations.

It would be preferable to have a new system in place across the four nations, but Emma Harper is right that we have to test it, particularly in advance of greater numbers returning from travelling out of the country during the festive break.

11:45

The Convener: Thank you, cabinet secretary. I think that Emma Harper is satisfied with that answer.

Am I right to take what you say as meaning that, if the capacity was there, it could be done and it could potentially shorten the quarantine period from the current 14 days to seven or eight days? Is the issue then whether the capacity to meet that and the other likely future demands on the testing system can be achieved over the next period?

Humza Yousaf: You are right that testing capacity is one of the key issues, and I stress that it would be private capacity. We do not want NHS capacity to be used for people who go to Lanzarote for a week for some winter sun. We want NHS capacity to be used for cases in the community. It would be private sector capacity, and that is increasing. It is scaling up to quite an extent and we need to make sure that the capacity is appropriate.

We also need to measure effectiveness. Our clinicians tell us that quarantine for 14 days is the effective measure, but there are questions about how often people really quarantine for the full 14 days, and whether they become less compliant when they tail off towards days 11, 12, 13, 14, especially if they are asymptomatic, and weighing that possibility up against the possibility of being released early from quarantine after a negative test. These questions are being probed now and we are expecting fuller detail imminently from the United Kingdom Government global travel task force, and we will try to work as four nations on that. There is a question about whether it is sensible to test any pilot like this before the festive break or during the off-peak season.

The Convener: No more members are indicating that they wish to ask questions. We now move to agenda items 3 to 5 inclusive, which are the formal debates on the made affirmative instruments on which we have just taken evidence. Are members content that we have a single debate covering all the instruments together? I see that members are content to do so.

I remind members that we are now moving to a formal debate and that the minister will move the motions. There will be no questions, as such, but,

if members wish to contribute, they should do so—you can indicate in the usual way.

I invite the cabinet secretary to speak to and move motions S5M-23216, S5M-23285 and S5M-23297.

Humza Yousaf: Thank you, convener. As always, I will waive the right to speak as we have just had a question-and-answer session. I will just remark that I have never known more about Danish mink farms than I do now.

I move,

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 20) Regulations 2020 (SSI 2020/343) be approved.

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 21) Regulations 2020 (SSI 2020/354) be approved.

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 22) Regulations 2020 (SSI 2020/358) be approved.

The Convener: As no members wish to have a debate on the motions, we will move directly to conclusions. Cabinet secretary, do you have any concluding remarks to make?

Humza Yousaf: No, other than to say that as soon as I receive detail and confirmation of any airport testing regime, I will ensure that the committee is informed.

Motions agreed to.

The Convener: We will report accordingly to Parliament and we will, no doubt, hear further from the cabinet secretary very soon in the way that he indicated. I thank the cabinet secretary and his officials for their attendance.

European Union (Withdrawal) Act 2018

Food Amendment (EU Exit) Regulations 2020

11:50

The Convener: We now move on to agenda item 6, which is consideration of a consent notification proposing that the Scottish Government give consent to the UK Government legislating using the powers in the European Union (Withdrawal) Act 2018 in relation to a UK statutory instrument. I invite comments from members.

Sandra White: I have raised this particular issue in relation to most EU withdrawal acts. It is to do with the Northern Ireland protocol. Page 4 of paper 3 mentions country of origin information. We know that the Northern Ireland protocol says that Northern Ireland produce coming into Great Britain—it is not called the UK in this particular protocol—will be labelled differently. However, the last paragraph on page 4, about country of origin information, mentions that this SI

“updates Article 1(2) to reflect new EU legislation covering, names of spirit drinks, ractopamine and the use of the names of spirit drinks in other foods, the use of geographic indications in this sector”

and

“adds a new Article 1A to define the United Kingdom as a whole to be a country rather than the constituent countries (Scotland, England and Wales could be used separately on labels under ‘place of provenance’).”

That is the issue that I am concerned about, but it does not necessarily mention that here. The paper also says that the instrument

“amends Article 2(a) to define ‘region’ or ‘geographic area’ to cover more than one country. This is to move away from the terms ‘Member States’ and ‘Third Countries’”.

I want a bit of clarification on that particular point. I know that, on page 5, the paper mentions the fact that the Scottish Government will keep in contact with the UK Government to continue to look at this and that it is still concerned about the Northern Ireland protocol and the continuity of law. I know that we wrote to the Government last week, or two weeks ago, and received a very good reply, and I do not want to hold things up, but I am concerned about this issue, particularly if one country is to be referred to on labels rather than England, Scotland and Wales, as separate countries of origin.

The Convener: That is an absolutely fair point. The recommendation from the office of the solicitor is that, if we give consent today, we

should ask for more information about that specific point, which certainly makes sense.

Emma Harper: My point is similar to Sandra White's. The Rural Economy and Connectivity Committee has also done work on similar statutory instruments. One that relates to country of origin, labelling, the traceability of food and food safety standards was about veterinary medicine residues, which are chemical residues that can be contained within the skin or the carcass of animals or meat as it is transferred from one country to another. Certain levels of residue are acceptable.

I am concerned that food standards might be compromised in future trade deals and I have been following issues relating to hormones used in beef cattle and pigs. There are issues about ractopamine and Carbamax, which is an antibiotic.

I note that the Northern Ireland protocol is something that the Scottish Government needs to continue to engage with the UK Government about. I am especially concerned about how we track and trace food produce coming from external countries. We should continue to be alert to that, and the Rural Economy and Connectivity Committee, of which I am also a member, will do the same.

The Convener: Thank you for that important point. If that committee is following up that point, it clearly falls into their domain more directly than ours, although, clearly, we have an interest. I ask you, as a member of both committees, to convey to that committee that we would be pleased to be kept informed of any reply that it receives.

The recommendation in the paper is that we should agree to give consent. I note that the draft letter from the office of the solicitor contains a number of important points, and I draw members' attention to the advice from the Scottish Parliament information centre as well.

Sandra White, I think you want to come back in on this before we move to conclusions.

Sandra White: Maybe I have jumped the gun a wee bit, as you might say. Emma Harper mentioned that the Rural Economy and Connectivity Committee would be looking at this issue, and you asked her to ensure that it kept us informed. For clarity, does that mean that the Health and Sport Committee will not be writing to the Government with the concerns that we have raised or the points that are outlined in the letter from the office of the solicitor?

The Convener: No, it does not mean that. My apologies if that was a confusing point. Veterinary medicines are clearly a matter that come under the remit of the Rural Economy and Connectivity Committee more directly than that of our

committee, but I was about to note a couple of issues that you had raised.

First, on the consequences of adding article 1A, defining the United Kingdom as a whole to be a country, it is important to understand what that means for the provenance of Scotland and of other parts of Great Britain and whether it would mean any material change. Secondly, we would also, as we have done previously, ask to be kept up to date on the Scottish Government's engagement with the UK Government on the Northern Ireland protocol. Thirdly, it is an improvement on past practice that we have, unusually but in a way that we would welcome, seen this SI in draft today, and that is something that we want to encourage and will welcome in our letter.

If members are agreed, I propose that we give that consent, subject to those points being raised in the relevant letter to ministers. Are we all agreed to follow that approach?

Members indicated agreement.

The Convener: That is agreed. We will now move into private session.

11:58

Meeting continued in private until 12:18.

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

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