OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Committee

Thursday 11 February 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 11 February 2021

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COVID-19 COMMITTEE
5th Meeting 2021, Session 5

CONVENER

*Donald Cameron (Highlands and Islands) (Con)

DEPUTY CONVENER

Monica Lennon (Central Scotland) (Lab)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Maurice Corry (West Scotland) (Con)
*Annabelle Ewing (Cowdenbeath) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Stuart McMillan (Greenock and Inverclyde) (SNP)
*Mark Ruskell (Mid Scotland and Fife) (Green)
Beatrice Wishart (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Grant Archibald (NHS Tayside)
Danny Boyle (BEMIS Scotland)
Dr Andrew Buist (British Medical Association)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Caroline Lamb (NHS Scotland)
Professor Jason Leitch (Scottish Government)
Willie Rennie (North East Fife) (LD) (Committee Substitute)
David Stewart (Highlands and Islands) (Lab) (Committee Substitute)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

Virtual Meeting

Scottish Parliament

COVID-19 Committee

Thursday 11 February 2021

[The Convener opened the meeting at 09:30]

Covid-19 Vaccination Programme

The Convener (Donald Cameron): Good morning. Welcome to the fifth meeting of the COVID-19 Committee. We have received apologies from Monica Lennon and Beatrice Wishart. I welcome David Stewart and Willie Rennie, who join us as committee substitutes.

This morning, the committee will take evidence on the Covid-19 vaccination programme from Grant Archibald, chief executive, NHS Tayside; Danny Boyle, policy and parliamentary officer, BEMIS Scotland; and Dr Andrew Buist, chair, general practitioners committee Scotland, British Medical Association. I welcome our witnesses to the committee.

We have a lot to cover this morning, so we will move straight to questions. Members will have approximately eight minutes each to ask their questions, and we will try to arrange those questions thematically. Please keep questions and answers as concise as possible. If there is time for supplementary questions, I will indicate that once all members have had the chance to ask questions. I remind members to indicate who their questions are directed towards, because that will assist broadcasting. Finally, as ever, please wait a moment for your microphone to be switched on before speaking.

The first theme that we will cover today is the Covid-19 vaccination procurement and distribution. Annabelle Ewing will ask some questions in that area.

Annabelle Ewing (Cowdenbeath) (SNP): Good morning, and thank you all for giving the committee your time this morning. On the day after Scotland has achieved 1 million vaccinations with the first dose, I want to take this opportunity to thank every person involved in what has been the most amazing roll-out of a vaccination that we have seen in our lifetimes.

Over recent weeks, we have seen reports of the distribution model from differing perspectives. I would like Grant Archibald and Dr Buist, from their different perspectives, to describe the distribution system and say how effective they think it is.

Grant Archibald (NHS Tayside): I agree with what you said about the achievement in relation to the number of vaccinations. Given that the vaccination roll-out started only on 8 December, it is significant that we have reached 1 million people. There has been a Herculean effort from lots of people.

In NHS Tayside, we believe that we have performed well in the delivery of the vaccine to the people we serve. NHS Tayside serves an area of 3,000 square miles, from Kinloch Rannoch to Dundee and to Montrose, and faces challenges of rurality as well as those to do with cities. Therefore, we adopted the model that we use for flu vaccinations. Along with our general practitioner colleagues, we used that as a dry run and we were successful in the delivery of the flu vaccination. As a result, the model in Tayside has involved some central points as well as delivery of the vaccine to GP practices—62 of them in total.

As a result of that model, I am pleased to say that we have achieved all the Government targets so far—indeed, we have outperformed—and, as we head into next week, we are on track with the delivery of vaccines, so we will continue to achieve those targets. In total, we have vaccinated 94,000 people out of an available population aged over 16 of 350,000. That means that 27 per cent of the population of Tayside have been vaccinated since 8 December.

There has been a lot of media commentary regarding the unevenness of supply—I think that Jason Leitch told this committee that there had been a lumpiness of supply. It is entirely true that the supply has not been metronomic—it has not been the same every day in an entirely predictable way. However, we have adapted our model to enable us to deal with that, working with our GP colleagues in particular. All the supplies of vaccine come into NHS Tayside centrally, and then we distribute it. That is slightly different from the model in other boards. Doing that is challenging, but we need to recognise that the vaccine takes three months to make and is coming in from abroad, so there are lots of complexities around it. I would say that we should be judged on our record. We have made adaptations and I have had great support from our GP community and our health and social care partnerships. As a result of that, we have been highly successful so far.

It is true to say that we face a difficult challenge—it is the biggest challenge that the national health service has ever faced and it is the biggest vaccination programme that has ever been undertaken. It is understandable, therefore, that it will be challenging at times. However, we continue to deal with the challenges, we continue to adapt and, thus far, we continue to deliver the targets that are expected of us by Government.

Dr Andrew Buist (British Medical Association): I am a GP and, by coincidence, I

am a GP in Tayside—one of the GPs Grant Archibald was referring to.

I have been critical of procurement and distribution, but I think that we are in a different place now from where we were three or four weeks ago. Now, we genuinely have a case for being proud of what we have done as a country. Passing the 1 million mark is a cause for celebration. This has been a massive task. I estimate that the programme is five or six times as big as the annual flu programme that we are used to delivering. We have done very well with the care homes, the over-80s and the relevant staff, working down the list of priority groups.

Four weeks ago, I was critical of what was going on and questioned the distribution model, but I think that improvements have been made. At the time, the model seemed overly complex. I cannot begin to describe it. People were saying that we should see whether it could be improved in any way.

I am aware that, as Grant Archibald said, Tayside has been operating a slightly different distribution model from other boards. I believe that, due to childhood vaccinations that were carried out several years ago, the board was given a wholesale licence, which allowed it to collect and store vaccines in a way that other health boards cannot. I think that that has helped in that health board area.

The supply issue has been a difficulty across the whole of the United Kingdom—it has been described, variously, as lumpy, bumpy, patchy and so on. However, that situation appears to be improving on the ground. As a GP who will be giving vaccines tomorrow in his own surgery, I can say that the supply, which was coming through in quite small amounts early on, has improved, and we are in a better position to vaccinate.

Annabelle Ewing: Reference has been made to the fact that NHS Tayside has taken a different approach from the one that is being taken by at least some other health boards, if not all of them. Dr Buist referred to the fact that NHS Tayside has a wholesale licence. Grant Archibald, could you explain a bit more about that? Do you think that other health boards should adopt that approach?

Grant Archibald: Although we regard Scotland as one country, rightly, there are differences across Scotland in terms of geography and concentration of populations. We have adopted a model here that allows us to reflect urban centres and the rurality that I described. As Andrew Buist said, we are in possession of a licence that, without being too technical, allows us to pack down supplies directly and issue them to GP practices. That model works for us, but it might not be transferable everywhere else.

All of us in NHS Scotland have been liaising constantly to make sure that we learn from one another. We should emphasise that we are breaking virgin territory every day, not only in Scotland but, in some respects, the world—other than Israel—in the vanguard of this work, so it is understandable that we should be adaptive. The model that we are using works well for us. I am less clear on whether it would be immediately transferable to others, but all of Scotland should be proud of what it has achieved. Importantly, that is the product not only of people such as Andrew Buist and me and the people who work with us, but of our population. The success of Tayside has been 416,000 people recognising their role in dealing with the biggest public health challenge ever, and I do not want that fact to be lost.

Annabelle Ewing: Thank you, chief executive. Dr Buist, do you share the view that every part of Scotland is its own island and has its own demographies, geography and priorities? From discussions with your GP colleagues, do you feel that they would prefer more boards to adopt the NHS Tayside approach, or do they not have a view?

Dr Buist: The demography and geography varies around the 14 health boards. As Grant Archibald said, each board needs to look at its methodology and learn from other boards. That model works in Tayside, which is not unique in its geography, and there are more rural health boards, so each board should look at the model that Tayside uses.

One of the advantages is that NHS Tayside has its own delivery vans, which it has sent down to the national depot to collect the vaccine, rather than having to rely on the distributor, and that speeds up the process. I invite all boards to look at the Tayside model and see whether it can be adopted. I do not know how long it takes to get a wholesaler's licence but I hope that something like that could be expedited.

Annabelle Ewing: Thank you.

Willie Rennie (North East Fife) (LD): It is fantastic that we have got to 1 million vaccinations, and I know that the vaccinators are working incredibly hard to make all this happen.

Andrew Buist is right about the distribution system at the start. We are still behind England, but I would like to see us catching up, because I think that we can.

My questions are about how the booking system works. We saw the problems in Fife on Monday with long queues, because about 7,000 people had been double booked, and that situation has continued to some extent in Fife during the week, although I am sure that it is just the overhang from the initial problem. However, I have heard of the

system booking in too many people for the capacity of the vaccination centres, and I am keen to understand whether that is also your experience. Also, those who have already been vaccinated by the GPs, such as the over-80s, are getting letters asking them to come forward for their first vaccination. Is that a problem? If they do not cancel the booking, what happens?

Grant Archibald: First, Willie Rennie's description relates to a national service called ServiceNow. NHS Tayside has not onboarded with that, so I am less able to comment on that than people from other boards. In Tayside, we rely so much on the relationship that we have forged with our GPs, which has been so purposeful. They have been making the bookings or we have been making central bookings at our mass vaccine centres in the Caird hall, the ice rink in Perth and elsewhere.

To my knowledge, I have not had any complaints regarding overbooking or long delays. Colleagues might know that we had a problem in Tayside. We had a pretty bad bout of weather, just to add to everything else that we were dealing with. That meant that there was one day when there was an unevenness of people presenting at the Caird hall.

09:45

Other than that, the concentration on using local centres in combination, importantly, with our GPs, who have been calling up and arranging for their patients to attend, has been very successful. We have already completed 88 per cent of the 75 to 79s and 45 per cent of the 70 to 74s. That is why I say that this is not about opinion but about evidence. We believe that we can show that our system is working. However, if there are any specific queries, I would be happy to take them up.

Dr Buist: The appointment and booking system is one of the biggest challenges that the whole programme faces. It has been described as building the ship as you float, because we have had to go from a standing start, and as a marathon rather than a sprint, yet we are fighting against the virus, so we have to move quickly.

In general practice, we use a system called Turas to book our own patients in. We tend to phone patients directly and give them an appointment, booked into Turas. They come in for their vaccination and the information is fed into the GP system.

I am less familiar with how the boards are doing the cohorts that they are vaccinating. I am aware that Tayside and, I think, Dumfries and Galloway and Highland are not using ServiceNow, but maybe they will do so soon. It is one of those complex areas in which improvements are happening all the time.

Mr Rennie mentioned patients over 80 who have had a vaccine in general practice and have then received a central letter. Obviously, that is undesirable, confusing and a waste of resources. Those little glitches need to be ironed out but, at the end of the day, such things should not hold us back. I think that everybody involved in the vaccination programme would say how well it has come together and how far we have come in just eight weeks, since we first received the vaccine. What happened in Fife this week was very unfortunate, particularly given the weather conditions that people had to stand in. That must not happen again, and I am sure that people are working to ensure that it does not.

Stuart McMillan (Greenock and Inverclyde) (SNP): I have a couple of quick questions for the panel. It was known in health board circles and in the Government that there would be fluctuations in supply from the manufacturers, but that information was not really in the public domain. Dr Buist said that it is amazing how far we have come in just eight weeks. Is that a fair representation, given BMA Scotland's criticism of health boards and the Government over the past few weeks regarding—to quote Dr Buist again—the "glitches" that have taken place?

Dr Buist: My job is to represent general practice, but it is also to make sure that programmes such as this are optimal. I really want the programme to succeed. Three or four weeks ago, I questioned some elements of the programme, as a critical friend asking, "Is everything optimal here? Your distribution system seems a bit clunky. Is there anything that we can do to improve it?" That was really all I was asking.

I also raised some other issues. One key aspect of the programme is to establish a vaccinator workforce. There was a time when the requirements that had to be met for someone to be certified as a vaccinator were excessive. I raised that issue and, to its credit, the Government quickly looked at what was being asked of volunteers and agreed that it was, in many cases, excessive. That was quickly sorted out.

We are building the ship as it floats and there will inevitably be small issues to resolve. I come from general practice and primary care and I bring a perspective that is useful for people in the Government to hear and which helps us to fine tune the programme. They have listened and have made changes and we are in a better place than we were three or four weeks ago.

Stuart McMillan: Notwithstanding your comments about the distribution, was BMA

Scotland aware that there would be fluctuations in the vaccine supply?

Dr Buist: The vaccine is a biological product and is made in a factory that is not in Scotland. Sometimes there are production problems. We get bits of information about that. There is nothing that we in Scotland can do about production problems, other than wait, but if there is a distribution problem, we can look at that. That was the point that I was making. We talked about Tayside's distribution model being different from the one used by other boards, and distribution is something that is still being looked at. The point was worth making and improvements have been made. Optimising the process was the right thing to do.

The Convener: Danny Boyle, do you have any observations to make about the experience that black and minority ethnic communities have had of the vaccination programme?

Danny Boyle (BEMIS Scotland): Before I respond to the question, on behalf of BEMIS and the ethnic minority national resilience network, I pay tribute to our NHS colleagues for their incredibly hard work. A huge number of people from black and minority ethnic communities work in that sector. I thank them for their continued efforts.

We know that there is vaccination hesitancy in BME communities in England and Wales and that it is becoming a concern in Scotland. I can give the committee an overview of the issues and where we stand.

BEMIS is a national membership organisation. In March 2020, we established what is now called the ethnic minority national resilience network. We did that as a way of responding to the Covid issues that we knew would come, and to enable communities to act in solidarity with one another. The network now has 96 members from communities across Scotland that self-identify under the protected racial provisions of colour, nationality and ethnic or national origin.

We see some similarities between the challenges that affect those groups and cause vaccination hesitancy, though other challenges are specific to certain groups. The resilience network has a sub-group that focuses solely on inclusive health messaging. That group has ramped up its work since the start of the vaccination programme in early January.

We have real-time information that changes daily. Two weeks ago, we instigated a survey of our members and of people further afield to help us to grasp some of the challenges that various communities face. I will give a whistle-stop tour of some of the current challenges.

The survey has had responses from 28 organisations across Scotland. We received responses from NHS Tayside, NHS Greater Glasgow and Clyde, NHS Lothian and other significant health boards that have large ethnic minority demographics. Respondents ranged from very small local community organisations that work with 20 to 30 people to much larger national organisations that work with 5,000, 6,000 or 7,000 people. All in all, across all organisations, we have had responses from groups that cover 45,000 to 60,000 people. We have engaged directly with those people.

From that survey, we got information on four key demographics that we have identified. Those include asylum seekers and refugees, newer arrivals—eastern Europeans, Polish people and citizens of the rest of the world—and multigenerational Scottish ethnic minority communities. The latter includes well-established groups including Pakistanis, Indians, Irish people, Jewish people, Sikhs and so on. The survey also considered specific problems and concerns that emanate from within communities that self-define as African and Black.

Some of the questions that people have are generic and reflect issues that affect the whole population. Those include how to get the vaccine, whether it is safe, what the side effects are and what it contains. Responding to those generic questions is about ensuring that we can share information and increase informed consent in a way that makes the information accessible for speakers of different languages.

I will highlight some of the specific concerns from the four demographics. In asylum seeker communities, if information comes from the Home Office or another official source, for example, there is routinely concern about responding to those normal practices, which all of us take for granted. That is because the Home Office could undermine the experience of those people and because they have a negative relationship with it. To respond to that, we need to share information in mother tongues via visual representation and through trusted sources such as local community organisations.

In newer migrant communities, including those from eastern Europe, we have established that there is a bit of a hangover from the H1N1 swine flu pandemic. There is a strong anti-vax sentiment within some eastern European demographics—younger populations, in particular. We have been told that that is due to an established pattern of the H1N1 vaccine having narcolepsy as a side effect. That sentiment has taken a strong hold in that community.

In multigenerational ethnic minority communities—Indian, Pakistani, Irish, Jewish and

some Polish—emphasis is on ensuring that we have the language capacity to engage coherently with them. All too often, we find that the language that is used is at too high a level and needs to be pulled back and simplified in order for people to understand it. That is the case with languages including Urdu, Punjabi and Mandarin. The response to that is best taken forward by local community organisations and trusted partners.

Racial inequalities that existed before the pandemic have been significantly exacerbated by it, but one of the most concerning aspects that has arisen is concern and misrepresentation in some groups that the process of vaccination still involves using some ethnic minority communities—particularly African and Black people who have suffered a history of racialisation—as guinea pigs.

A wide range of things orbit this issue, and we need to respond to them. We have support from the Scottish Government to ensure that we can proactively respond by allocating resources to local community organisations so that they can create the bespoke responses that are required to increase vaccination rates within those groups.

I will finish with probably the single most important point. We do not collect ethnicity data at the point of vaccination or during the process. Therefore, at present, we are not able to benchmark where there might be continual lack of uptake in some ethnic minority communities. Ideally, we would be able to measure that as we move through the vaccination programme, so that if we had to reallocate resources to particular ethnic groups, we would be in a position to do that.

The Convener: That was a useful overview of the various issues. Willie Coffey has a supplementary question, before we move on to the general theme of vaccination hesitancy.

10:00

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): That was helpful and informative. Is anyone doing any research to help us to understand why certain groups of people, particularly certain ethnic groups, seem to be more vulnerable to the virus? Dr Buist, younger people also seem to be picking up the virus and becoming seriously ill, and some are dying. Is any research being done to help us to understand why that is happening?

Danny Boyle: That is a good question. As part of the expert reference group on Covid and ethnicity and our work with the Scottish health and ethnicity linkage study, we found that pre-existing vulnerabilities to respiratory illness, particularly among Pakistani males, are reflected in the available mortality data for Covid and ethnicity. The only disaggregation of mortality data with regard to ethnicity covers the period from 12 March to 14 June, during which time there were 4,070 individuals whose deaths involved Covid. However, we know that between June and February there were 4,656 further deaths for which we have no disaggregation by ethnicity.

Deaths as a result of Covid or involving Covid are twice as prevalent among south Asian people, and, within that group, the key risk group is Pakistani males. As we understand it, that is the medical complication, but there are long-standing socioeconomic inequalities among ethnic minority communities, including housing overcrowding, which contribute to Covid vulnerability. In my first answer, I spoke about pre-existing inequalities being exacerbated by the pandemic, which is very much the case with regard to the impact of Covid in Scotland and the challenges of socioeconomic disadvantage and pre-existing health vulnerabilities.

Dr Buist: I have no doubt that an area of intense research interest is whether there are racial differences in the propensity to contract the disease, as well as comparisons in that regard between people from India or Pakistan who live in western countries and those who live in India or Pakistan. On Danny Boyle's last point, undoubtedly the propensity to get the disease is linked to exposure, and living in more crowded housing situations causes people to pick up the disease and to pass it on. Therefore, there is a massive relationship between socioeconomic deprivation and catching and suffering the consequences of the disease.

Similarly, people in the health and social care workforce, particularly carers, often come from minority groups and can have greater exposure to the virus as a result of working in care homes or intensive care units. Exposure to the virus makes them occupationally more prone to it, which is also a concern. The most obvious risk factor for the virus, apart from age, is socioeconomic deprivation.

The Convener: Vaccine hesitancy and misinformation generally form our next theme. Several members have questions on that, starting with Mark Ruskell.

Mark Ruskell (Mid Scotland and Fife) (Green): To follow on from the last answers, how do we access other disadvantaged groups in society? I am thinking about homeless people and drug users, for example. Are GPs adequately resourced to address vaccine hesitancy and to reach out to those groups, or is there a need for a deeper community partnership? I am trying to get a sense of whether there are any gaps in the reach of the vaccination programme and whether there is a need for outreach to those groups that might be holding back.

Dr Buist: At the moment, we are working our way down the priority groups, for whom, as per my previous answer, the highest risk is age. We will be coming to the under-50s fairly soon, I hope. We may get on to the difference between the model that we have adopted in Scotland and the one that has been adopted in England. The health boards have lead responsibility for delivering the programme, and GPs get involved at the request of the board to reach harder-to-reach groups, which may well include people who are homeless or who have drug problems.

People fall into different categories, including those who do not want the vaccine and those who just find it difficult to access healthcare. Clearly, setting up a clinic in a homeless centre might be a very good way of reaching out to people who otherwise might not come to an appointment.

People who are not keen on having the vaccine need a different approach. We need to boost the evidence base when it comes to the vaccine's safety and efficacy—again, that will be an area of intense research interest just now—and that will encourage more people to take the vaccine. We need role models who those groups identify with to come forward, be vaccinated and tell their friends that it is okay.

Perhaps in time we will come up with the benefits of being vaccinated. We have talked about passports for travel. I have no doubt that being vaccinated might bring other benefits when it comes to accessing things such as cinemas and restaurants. I am sure that that is being looked at.

Mark Ruskell: Obviously, we are working through the Joint Committee on Vaccination and Immunisation priority groups. However, some GPs have called for more discretion in how they deploy vaccines—particularly for low-income communities and groups that are disadvantaged. There may be a desire to vaccinate those who are under 50 but who are in a very vulnerable position in relation to their health—[*Inaudible*.]—and inequalities.

Dr Buist: I agree with your point. I think that it comes down to the amount of vaccine that we have available, which has been very limited up to now. We have literally had deliveries of maybe 100 or 200 doses. Early on, we were getting those sorts of volumes in my practice, yet we had 600 people over 80. That group was at a much higher risk of doing badly if they caught Covid, so it would not have been right to use some of that vaccine on harder-to-reach groups.

However, as soon as more vaccine is available, I think that discussions should take place locally between boards and practices—particularly those that are serving more socially deprived areas—so that perhaps GPs can administer vaccine to patients rather than those people having to get one or two buses to a mass vaccination centre. One of the key things behind the Scottish model is much more local flexibility, and it is up to boards, in discussion with their GP practices, to make use of that.

Mark Ruskell: Thank you.

Danny Boyle: Responding to the latter part of Dr Buist's answer, we are of the opinion that there is a strong case to be made that, as vaccine becomes available and we have greater capacity to—[*Inaudible*.]—things out for the JCVI prioritisation list to take into account factors that others have identified including socioeconomic status, housing and employment.

Returning to my earlier point about Pakistani males being twice as likely to die of Covid, we also know that that demographic is more likely to live in social and economic disadvantage and to work in what we would now term the informal front line. That employs a significant number of people from minority ethnic communities as taxi drivers, small business owners and shopkeepers. We know that the biggest vulnerability is age and exposure, but when we add in those additional challenges, there is a strong case to be made, given the data that we have on the mortality rates and dangers for people from that ethnic group, for adding them to the JCVI prioritisation list.

John Mason (Glasgow Shettleston) (SNP): I will pick up on some of the points that Danny Boyle made and press them a bit. Language was one issue that was raised. What does a GP do, Dr Buist, if there is a language issue in the constituency? Presumably some GPs see a lot more people from ethnic minorities. I am thinking particularly of older people from a Pakistani background in Glasgow, for example, who might have more issues with the language. How have GPs been able to handle that?

Dr Buist: There are two main ways that we deal with it. One is to ask the patient to bring one of their family members or someone they trust to translate in the consultation room. If that is not possible, there is a system called LanguageLine UK that involves phoning a centre and having a three-way conversation. It is a bit more time consuming than having a family member or friend with the patient. Those are the main ways in which it is done. How much the system is needed varies enormously around the country. In my practice in Blairgowrie, I have probably used it only a couple of times, but when I did a locum in Benbecula in the Western Isles two years ago, I used it about six times because there was quite a high Russian and Polish population there with the fishing industry. It varies between practices how often they have to use that system, which puts significant additional demands on the practice

capacity because of the time it takes. If those consultations are done properly, they take longer.

John Mason: Danny Boyle suggested that there is not a lot of data about uptake of the vaccine. We know that uptake is generally pretty good, but would a GP practice pick up whether a high proportion of ethnic minority folk, for example, did not come for the vaccine?

Dr Buist: They would not at present. The main criteria that we are using to invite patients to come for the vaccine are, first, age or location in a care home and, secondly, whether they have a significant long-term medical condition. There are on-going discussions about collecting ethnicity data more consistently. I believe that, when a patient registers with a GP practice, there is an option for the patient to state their ethnicity, if they want, but it is not always collected. There is a desire to improve on that, but that will take quite a time to do. I certainly do not see us having that data available in 2021.

John Mason: A GP practice in the east end of Glasgow, in my constituency, told me that it does not have a phone number or an email address for quite a lot of its patients, so it finds it hard to contact them. Would that be the case in a lot of poorer areas?

10:15

Dr Buist: We try and capture telephone numbers—including mobile phone numbers, because even among our more deprived patients, many have mobile phones rather than a land line—and record that information in people's medical records. However, there are some people whose socioeconomic situation is so bad that they do not have any access to a telephone. That is a significant issue.

John Mason: Danny Boyle, on the issue of language, are GPs coming to you for help? Do you think that the GPs are handling the situation in a way that enables them to contact folk from an ethnic minority background?

Danny Boyle: What has been helpfully demonstrated today are some of the systemic challenges that have been illuminated by the pandemic but which existed before it. Those challenges involve the ways in which we, nationally, as well as through local boards and GP practices, engage with the diverse communities of Scotland, either successfully or not.

A lot of emphasis has been placed on language today. That is an incredibly important issue, and I spoke earlier about the survey identifying long-standing issues with multigenerational ethnic minority communities such as the Pakistani and Indian communities. However, there are a lot of communities in relation to which we have not successfully built a bridge between individuals and a GP. In many cases, people in those communities have not registered with a GP and do not have access to services that are required to get us all safely through this pandemic. I spoke earlier about issues relating to asylum seekers and about a lack of GP registration within some eastern European communities.

John Mason: Are you talking mainly about younger people? So far, we have been dealing with over-80s in the vaccination programme so, if the people you are talking about are mainly younger people, that could become more of a problem as we go forward.

Danny Boyle: That is accurate. I will use the Polish community as an example, based on the survey responses that we have received. People in that community who are aged over 50 and are active are keen to take the vaccine. However, there is more hesitancy among younger people who are working.

With regard to the specific question about whether the language provision in GP surgeries has an impact on whether people can access services, we have not had any responses that say that that is an issue. However, Dr Buist mentioned people attending services with family members to translate. Obviously, at the moment, because of the Covid restrictions, that is difficult. There have been instances where that has not been possible. Also, there is an issue with the letters that invite people to attend for their vaccination. That is a live issue, and it has been flagged up that those letters should also be available in people's mother tongue.

We are aware of those issues and are trying to respond to them at the moment. The issue of data collation and getting systems ready to respond to that will have to be addressed over a longer period of time.

John Mason: On the point about data, are you aware of plans to improve the data? Obviously, that will involve the NHS rather than the GPs.

Danny Boyle: Yes, it is on the table to be considered. The expert reference group on Covid and ethnicity has made recommendations in that regard, as have we in the ethnic minority national resilience network. Data collation based on the census codes has to become the default mode of practice for every public service so that we can get a clear view on where there are gaps and challenges. I do not want to take the committee down the road of the much broader debate that we are having at the moment, but there is a significant lack of understanding within many public services about what we mean when we talk about racial

minority and ethnic minority communities and who falls into those categories.

Maurice Corry (West Scotland) (Con): Good morning, gentlemen, and thank you for all the work that you do to make the roll-out of vaccinations successful. We appreciate that and all the various roles that you play.

My first question is to Grant Archibald, and it is about communications to the general public and how you are dealing with vaccine hesitancy and misinformation. What tactics are you adopting to drive successful outcomes?

Grant Archibald: Thank you very much for that important question. Communication has been at the heart of everything that we have tried to do. It is very important, both to build confidence in the community that we serve that vaccines are safe and appropriate for use and to ensure that we are organised and efficient in delivery to those who are most in need.

The JCVI and so on have done great work in identifying all the priority groups. NHS Tayside has a broadcast from my director of public health, Dr Emma Fletcher, every Wednesday, which tries to encourage people by telling them in very clear language about the progress that we are making and about any key indicators on where we need to go. Our Facebook outreach assessment says that we have reached 110,000 people through that communication alone. We have also used local media to support us.

We have not seen great levels of hesitancy thus far, and we have found that people have made a considerable effort to turn up on time for their appointment. That is very encouraging. However, we recognise that the whole community is not homogeneous and that there are different people in different areas. Therefore, we have had vehicles outreach into some of our more rural areas to make the vaccine available there.

If you will bear with me, Maurice, I will build on the commentary that we have just heard from colleagues by saying that we have a dental van that goes out to the homeless and others to ensure that they get basic dental care. We are considering whether that would be an appropriate vehicle—no pun intended—to use to reach out to those groups that John Mason and others described.

We are constantly adapting our engagement. The feedback thus far, given the amount of attention that is reflected from our media communication and other efforts, encourages me that we are reaching out to people and, importantly, that we are doing so in three ways. The first way is by using clear and basic language, the second is by encouraging people about the efficacy of the vaccine and its importance, and the third—which is most important—is by telling them that we are all in this together.

The vaccine is but one tool. The real success is that 416,000 people who have had their lives turned upside down for 330 days continue to work with us and support us by wearing masks, keeping their hands clean and engaging only with appropriate people in their family circle. If they do all that, the vaccine is a further tool to help us defeat this pandemic.

Maurice Corry: That is very helpful. Are there any gaps that need to be filled in your communication programme? You seem to be doing a tremendous job—well done—but are there any blue-sky objectives that you would like to have if we could persuade the Government?

Grant Archibald: We are constantly learning. Andrew Buist talked about being a “critical friend”. That is so important. We need to understand that, as we manage this and are in the vanguard of it, we need to respond to criticism or critique in a way that further improves what we are doing. All of us—me, Andrew Buist and everybody on this call—want Scotland to be successful in delivering the vaccine to our population and making people as safe as possible. That means that we need to embrace it if, on occasion, people ask, “What about doing it this way or that?”

Even if we are working hard, we all have to work hard at the right things. As Jason Leitch has often articulated, the right things change as Covid changes. We have long Covid now and we have other engagements that we need to make.

My view is that the messages from Government have been clear. The constant engagement with the public has been great, and the public’s engagement with us has been fantastic.

As John Mason and others have identified, we need to ensure that people do not slip through the net—that people are not forgotten in that process. Thus far, I am entirely encouraged that our engagements in Tayside have been positive, supportive to our population and rewarded with the behaviour of our population.

Maurice Corry: I turn to Danny Boyle. It was interesting to hear about the surveys and how those are going. What is the response rate? How many completed surveys are received for every 100 sent out, for example?

Danny Boyle: The survey is sent to all our network members and colleagues. It is shared on social media, and we ask that it continues to be shared. Every Friday, we meet our colleagues from the Scottish Government’s race equality unit. We pore over the responses that have come in, and that feeds into the Scottish Government’s communications response, We also respond more

directly to those communities, by giving them financial support to create the information and hold the necessary events online—sometimes trilingual or multilingual events—to start moving the needle on these hard-to-reach communities' perception of the vaccine, its efficacy, why it is important to get it and why it is safe. That is one week old—in the first week, we had 26 responses. Next week, we will review it and update it, so it is a continually evolving tool.

Maurice Corry: How many surveys did you issue?

Danny Boyle: I will need to check that, because it is done on a rolling basis—it could be 200; it could be 5,000.

Maurice Corry: That is fine. Well done on the work that you are doing with those communities.

Dr Buist, in your area, there are quite a lot of armed forces veterans, and a lot of NHS staff are reservists. Have issues or concerns been raised with you by veterans who served in the Gulf war? I remember that there were issues with vaccinations, possibly resulting in Gulf war syndrome. From your surgeries or your colleagues, are you aware of a kickback from that sector resulting in hesitancy to come forward for vaccination?

Dr Buist: So far, we have seen very little vaccine hesitancy. I estimate that it is at about 1 per cent. To compare that with the annual flu vaccination programme, somewhere between 15 per cent and 20 per cent of people will refuse that, because they do not believe in it, believe that it made them unwell in the past or just do not want it. So far, vaccine hesitancy has been remarkably low, but we must remember that, because we are going through the JCVI priority groups in order of risk, we are starting with the oldest patients. By and large, we have not vaccinated people under 70 unless they have a significant medical history, such as diabetes or chronic obstructive pulmonary disease or because they are on immunosuppressants or similar drugs. I have no doubt that there will be some military veterans with long-term conditions in that group, but as far as I am aware, so far, vaccine hesitancy has been remarkably low.

The Convener: Our next theme is international distribution. John Mason and Stuart McMillan have questions on that.

John Mason: Convener, I have had my slot today, so I will leave it at that.

Stuart McMillan: I am looking at the number of vaccines that have been ordered for the UK. There are a vast range, some of which will arrive later in the year. The UK's population is about 66 million. Do you believe that, in due course, it would be right to send those vaccines to other countries—particularly countries that we have links with, such as Malawi and Rwanda—to assist with the vaccine roll-out there?

10:30

Dr Buist: I will have a go at answering that question, although it is not one that I am particularly qualified to answer. Clearly, the Governments have spread their bets by ordering from several different companies in order to ensure that they have more supply than we need for our population. They have done that on the basis that some of the companies might have production problems, which we are aware that they have had.

In answer to your question, therefore, I suppose that I would say yes. We are aware that the virus is international and that people in more deprived countries need the vaccines just as much as we do, so it would seem to be the right thing, having overordered the vaccines, to allow some of the supply to be given to countries that are more deprived, such as Malawi and Rwanda, as you mentioned.

Danny Boyle: I echo the spirit of Dr Buist's answer. The UK or Scotland tends to be a good global citizen and is a leader in international human rights and a human rights-based approach. We should welcome anything that we can do to help to curb the pandemic and vaccinate people around the globe against the virus.

I caution only that any distribution of vaccines to international partners—particularly to those that suffer from significant imbalances in power dynamics and socioeconomic disadvantage in comparison with the UK, alongside a historical relationship with us—would need to be accompanied by an education programme, recognition of the issues and, potentially, deployment of their diaspora communities in Scotland and the UK to assuage any fears in those jurisdictions about who was to receive vaccines from the UK or Scotland.

In principle, however, it makes sense and—most important—it would just be the right thing to do.

Stuart McMillan: Your comment regarding the diaspora communities is extremely important. That is not something that I had considered. Do you have any suggestions that might assist?

Danny Boyle: If we look at it from the perspective that Africa is the continent that is most affected by a history of racialisation and colonialism from the UK and Scotland, we can see that there persists in some of the African communities in Scotland—due to that experience

of racialisation and the trauma of colonialism—a misunderstanding, even as the vaccine is being deployed in Scotland, that they may be being used as guinea pigs or that they are getting a different vaccine from the host population.

That will not be the case in every circumstance, but it is certainly something that we would need to be aware of if we were to share any surplus vaccines with post-colonial countries, or those that have suffered colonialism, in order to make sure that that narrative is not perceived as coming from what would essentially be a good place.

In that regard, some of our biggest assets would be our diaspora communities here. For example, Scotland has a very close relationship with Malawi and there are large populations here from other African nations such as Kenya and Nigeria, with whom there could be a relationship. Progress could be made on that level. However, those are matters of international affairs. We just want to put it out there that such things should be considered.

Stuart McMillan: I have a final brief question on the subject. Are voluntary international agreements and collaboration enough to ensure the equitable distribution of vaccines around the world, or would you like to see something more robust?

Danny Boyle: The distribution of vaccines strays into territory that is not our area of expertise. However, on international consensus and engagement, there are great examples of United Nations treaties and collaboration within the international system in which nations have come together to make rapid progress in areas of global significance. Racism is an example, via the International Convention on the Elimination of All Forms of Racial Discrimination.

UN collaboration on the distribution of vaccines, taking into account all the global lessons that we have learned about disproportionate impacts, socioeconomic status and minority groups in particular countries, would seem a utopian way to take those challenges forward, as well as a much clearer consensus within critical bodies such as the World Health Organization and the participation of key nations.

The Convener: Willie Coffey has a supplementary question on that topic.

Willie Coffey: This question is also for Danny Boyle. It must be welcome that the United States will be rejoining the World Health Organization. That is bound to have a positive impact on some of the countries that we have mentioned. However, is anyone picking up that some of those countries may need help from us—or from anyone—to manage their mass vaccination programmes? We are reasonably well advanced in how we contact our citizens and manage the data relating to them and so on, but are we picking up that countries such as Malawi need a bit of assistance to manage that process effectively?

Danny Boyle: I cannot answer the second part of the question. I will leave that to my colleagues who have expertise in distribution.

On the first part of the question, it is incredibly important that the USA is re-engaging with the international system. From a race equality perspective, the past five years, under President Trump, have been extremely difficult. There is no doubt that what an American President says and does in his jurisdiction has a knock-on impact on Scotland and the UK. I emphasise that the reintegration of the USA into the WHO and the international system of collaboration is welcome, and we hope that we will see the benefit of that in future.

Willie Coffey: Dr Buist, do you have any information on whether countries such as Malawi need help to manage their mass vaccination programmes?

Dr Buist: To be honest, I do not. That is quite far outwith my area of expertise. I know that there are close links between Scotland and Malawi, which is a country that I have visited. It has a very limited infrastructure, so I think that it welcomes any support that countries such as Scotland can give it.

The Convener: Our next theme is scenario planning and looking ahead. I have a question on that, and Stuart McMillan would also like to ask about it.

My question is about the medium term, and I direct it to Dr Buist first. I asked Jason Leitch the same question at last week's meeting. Do you accept that, in the next month or so, as we move down the JCVI categories and, at the same time, people start coming back for their second doses, there is potential for a crunch point of demand? If so, what plans are being put in place for GPs to deal with that? I will come on to health boards in a moment.

Dr Buist: It will become more challenging and the pace is going to pick up. We have done it in the right way in Scotland by prioritising care home residents and staff and then the over-80s and so on. I do not think that other countries have done it quite as thoroughly as we have.

As we come round to delivering second doses, that will coincide with the vaccination of younger groups—the 60 to 65 group, or even the under-50 group—so we will have to pick up the pace in our delivery capacity. That is why—I am surprised that I have not been asked about this yet—I was very supportive of the Scottish Government's choice of model, which is different from that in England.

In England, GP practices were given access to the vaccines and asked to get on with delivering a mass vaccination programme. I felt that that was the wrong approach, as did the Scottish Government. We went for a much more flexible, collaborative model in which GPs would help to vaccinate the harder-to-reach groups, such as the over-80s, and perhaps people with health inequalities, as has just been discussed. That is because general practice does not have the capacity to do the task alone.

As I mentioned, the Covid vaccination programme is five or six times bigger than a normal flu vaccination programme. Although we want to be part of the programme—it is an all-hands-on-deck situation—we cannot walk away from our core responsibility of being available to people who continue to get unwell and need to see us. We must therefore juggle our availability and do that while also vaccinating people. Tomorrow, for example, I have 22 appointments at my surgery in Blairgowrie—there will be 11 in the morning and 11 in the afternoon—and, in the middle of the day, I will vaccinate 11 people with the Oxford-AstraZeneca vaccine.

Returning to your question, I note that we will have to pick up the pace. The mass vaccination centres that we have developed around the country are critical to that, because we need that additional capacity. I think that we will continue to need it for the next 12 months, because my understanding is that it is likely that we will need to deliver Covid vaccine boosters. Ideally, that could be done in combination with and at the same time as a flu vaccine.

Furthermore, we are starting to talk about perhaps vaccinating everyone, including children. Such a massive programme would need significant standing capacity, which general practice could not deliver by itself, so we need the community and mass vaccination centres to continue for the foreseeable future.

The Convener: I pose the same question to Grant Archibald in relation to the position of NHS Tayside.

Grant Archibald: It is such an important question. I will make two or three observations. We are planning for the vaccination situation to get more complex, rather than less, in the next couple of phases, as we give people second doses and take on more of those who we are yet to vaccinate.

As I have said—I do not want to overstate this point, but we need to be careful not to understate it—this is an incredibly complex task. Vaccination has never been done on this scale or at this speed. A year ago, no one even knew that a vaccine would exist. Indeed, at that time, we were only getting the first indications that Covid-19 existed. In health terms, we are quite new to dealing with such a situation.

By my calculation, we have been vaccinating for 55 days. Every day has been a learning day, because every day we are trying to do it better. For the next stage, I am relying heavily on my public health colleagues for modelling. We benefit from having a lot of good data on which people will need their second vaccinations and when, and on those who still require their first doses. We have already articulated that, in order to provide those vaccinations, we rely on the vaccines being available; we understand that aspect, too. I am confident that our well-established plans are continuing.

I will amplify a couple of the points that Andrew Buist made. In my area, we have been fortunate in that the GPs are vaccinating for us, including Andrew and his colleagues in the practices, in addition to discharging their other duties and dealing with the unwell population. I still have people coming to emergency departments and people requiring theatres, and ladies are still giving birth.

I have stressed that Tayside has an adaptive model. We have opened the Caird hall as a mass vaccination centre, which was part of our planning. As we progress with the vaccination programme, we will need to rely on that, not least with the more mobile population—it is more reasonable to ask the younger population to travel.

10:45

It is a challenge with many moving parts, and our response continues to be adaptive. The encouragement that I can offer the committee is that we are on this and we are managing not just what is happening now, but what will happen next. In my experience, we are fortunate in Tayside that we have such a great cohort of GPs and others working with us and delivering the vaccination programme, because no one part would be able to deliver it on its own.

The planning is in place and we continue our adaptive response to what is happening with the vaccines, including on the basis of the best intelligence from the JCVI. I am confident that our plans are robust, and we will continue to adapt. It will be mission very difficult, but not mission impossible.

The Convener: Several members want to come in on that and I want to cover a final theme before we finish, so I ask for concise questions and answers.

Stuart McMillan: Is it fair to suggest that that scenario planning will be a fast-moving feast that

will continually change because of events that will affect some of the existing scenario planning and events that we do not yet know about, perhaps in a few months' time, which could result in the need to consider another wide variety of plans?

Grant Archibald: Yes—that is entirely so. I have used the word "adaptive" several times in my narrative to the committee, because such an approach is what is required. I go back to the point that Scotland and the UK are breaking new ground. We are in the vanguard in how we are doing vaccinations and the reaction to that with regard to the vaccine itself and public engagement. As Andrew Buist said, we are fortunate that the public in Scotland have embraced the idea of vaccination.

You are entirely right that we need to be adaptive and fleet of foot, and we need to recognise that, at times, there will not be an even distribution. There will be spikes and events that are not predicted. Thus far, however, Scotland's record stands up to anybody's scrutiny with regard to our ability to respond to the initial and subsequent challenges and, in particular, getting mass vaccination up and running in such a short time. We will remain vigilant and adaptive to what comes next.

Dr Buist: I entirely agree with Grant Archibald. We have a—[*Inaudible*.]—and Mr McMillan's comments are fair. Once we have given out the vaccines, we will have to quickly look at any gaps—any groups that have been missed—and target them for vaccination. Supply is a big limiting factor at the moment, but we have a good model and I am confident that it will continue to succeed.

Danny Boyle: Mr McMillan is correct that it is a fast-moving situation. We have a positive relationship with Government on accessing resources to ensure that we can develop assets for local communities to move the needle on vaccination uptake, but two key things that affect our position are still missing. We do not know the ethnicity of anyone who has died since July 2020 and we do not know the ethnicity of people who have taken up the vaccine. Those two key data issues remain unresolved.

Willie Rennie: It has been suggested that, once we have vaccinated the over-50s and those with health conditions, we should move on to vaccinate specific groups of workers such as teachers, postal workers and police officers. Mr Archibald, do you imagine that your delivery map will change so that vaccinators will go to workplaces rather than workers going to vaccination centres?

Grant Archibald: Which key workers will be vaccinated next is a matter for Government. With regard to accessibility, we need the best models for the highest success rate for the most efficient vaccine delivery. The model that Mr Rennie suggests, of vaccinators visiting workforces rather than workforces travelling distances to central points, is one that we might consider. Obviously, we would look at that following a decision by Government that we should engage in that way.

Mark Ruskell: From what I have heard this morning, it seems that there is a balance to be struck between national centralisation efficiencies and appropriate delivery in communities. Going back to the booking system, I note that you have yet to transition to the ServiceNow national booking system. Do you have concerns about that, given the chaos that we saw in Fife this week? Is the Turas system that GPs are using to roll out bookings working effectively? Is the balance right between the national system and—[*Inaudible*.]

Grant Archibald: We will be onboarding—I think that that is the term that is used these days—with the national system at some stage. There is a phased approach across Scotland, and occasionally there might be challenges. As I said, we are in virgin territory. We are doing new things in different ways and at speed. Ultimately, as Andrew Buist commented, it will be essential to reflect on and adapt our models as the volume of people that we are seeing changes and we hit certain peak points,. As I hope that I have said from the start, we must therefore adapt.

We have a mobile model in Tayside. Ultimately, we will onboard with the national system that is being rolled out elsewhere, but that will be done at an appropriate time for the population that we serve. I made the point—and Mr Ruskell put it very well—that there is absolutely a national interest and national direction on what we do, but we are all challenged as chief executives to make the best delivery models that we can, contingent on our populations.

As I have tried to describe, people might think of Tayside as Perth and Dundee, but it is not just that. It is 3,000 square miles going right up the glens and right out to the coast in Montrose. With my colleagues, I need to put in place models that are sponsored and accepted by Government and, importantly, sponsored by people such as Andrew Buist and his GP colleagues in order to ensure that we make the best arrangements at the time. It is entirely predictable that we will move to the national model, but we will phase that in, contingent on the population that we are seeing at the time.

The Convener: Our final questions, which are on the issue of vaccine passports, are from David Stewart.

David Stewart (Highlands and Islands) (Lab): Good morning. I am interested in some of the bigger-picture strategic issues. There has been a

lot of coverage of the possibility of vaccine passports, and the Tony Blair Institute for Global Change has looked carefully at that. In fact, the European Union is well ahead on the issue, after considerable pressure from the Greek Prime Minister. It is looking at a system within the EU, which it is hoped might spread across the world. As witnesses know, we have a yellow fever immunity passport, as we heard from our advisers earlier this morning. Has the BMA discussed that? What is Dr Buist's view—[*Inaudible*.]—and weaknesses of an international digital vaccine passport?

Dr Buist: Yes, we have discussed it. In fact, it was a motion at our GP conference in December, and GPs are very much in favour of it. Mr Stewart used a critical word: "digital". We want it to be done in as seamless a way as possible. The last thing that we want is patients going to their GPs looking for a piece of paper or a certificate that says that they have been vaccinated.

For some months, we have been asking the Covid vaccination programme board to try and ensure that the system that records whether people have been given a vaccine has the capability to produce some sort of IT proof. I have heard that in Denmark, a qwerty code is sent to the phone of a patient who has had both doses of the vaccine.

I am in favour of it being done as seamlessly as possible. Obviously, there are political questions about what it means—whether people will be required to have it to go on an aeroplane or into other crowded spaces and if it comes with social privileges. That was one of the reasons why there was some reluctance to talk too openly about it early on. However, it sounds as though it should be given serious consideration.

David Stewart: That is very helpful. I was not aware of the motion at the BMA conference; that is extremely useful information.

The key issue that I am concerned about—you might argue that this issue is more for policy makers—is that that train has left the station, in that the EU has discussed it already. Individual companies and airlines will adopt it. For example, Qantas, in Australia, has already adopted it as a way in which people can travel.

Does Grant Archibald want to make any comments about his assessment of that from a front-line perspective?

Grant Archibald: As you reflected, it might be more appropriate to have that conversation with the Government and policy formers. However, anything that encourages us to understand the penetration of the vaccine in the population and the safe travel of people around the country is worthy of consideration, because this will not go away in a number of weeks; it will be with us for some time. Clearly, health boards and others would respond to any request to be involved in that.

David Stewart: Mr Archibald, I appreciate that my questions relate to policy, but has that issue been raised at board level or from any of the policy officers in your own health board? Have you had a discussion within your board at senior level?

Grant Archibald: It has not been raised. The issue has been that—as you will understand—we have been providing not only the vaccine but emergency health care, home care and other services with colleagues in council and social work departments, across the population. That has not changed. Our time and concentration have been committed to that and to dealing with the acute phases of Covid and with the vaccinations. However, as players on the front line and people with a stake in the game, we would be available to offer our opinions if they were requested. Your narrative is persuasive.

David Stewart: Mr Boyle, what is your view on that? Has it been discussed at all in your network of organisations?

Danny Boyle: That issue is slightly further ahead of where our conversations are at the moment. The focus of our conversations and engagement is on increasing consent, and ensuring that people give informed consent, to receive the vaccine.

David Stewart: Could you take it away and discuss it with the network of more than 90 organisations that are involved with BEMIS? It is a long-term issue that will happen whether we are—[*Inaudible*.] Clearly, organisations such as the WHO are key to deciding whether it will be done internationally. However, I would be very keen for your organisation to give its views.

Danny Boyle: Absolutely. I will take that on board. It is certainly well within the realms of possibility that that could evolve to have a significant impact on our communities.

We also have the EU exit and its impact to contend with, as well as quarantine, the question of how long this will last and the issue of families being split up. There is so much going on at the moment that we have decided to focus on informed consent.

I extend an open invitation to any committee members who would like to meet the network or speak to the network about any of those issues to do so.

David Stewart: Thank you. Those were very helpful answers.

The Convener: I thank all our witnesses for their evidence and their time this morning. That concludes our consideration of this agenda item. I will now suspend the meeting for five minutes to allow for a changeover of witnesses.

11:00

Meeting suspended.

11:05

On resuming—

The Convener: We move to agenda item 2. We will take evidence from the Cabinet Secretary for Health and Sport, Jeane Freeman; Caroline Lamb, chief executive of NHS Scotland and director general for health and social care; and Professor Jason Leitch, national clinical director for the Scottish Government. This item gives members the opportunity to take evidence on the Covid-19 vaccination programme and this week's ministerial statement on Covid-19. The committee will go on to consider the Health Protection (Coronavirus) (Restrictions and Requirements) (Miscellaneous Amendment) (Scotland) Regulations 2021 and the Health Protection (Coronavirus) (Restrictions and Requirements) (Local Levels) (Scotland) Amendment (No 15) Regulations 2021.

Welcome, cabinet secretary, and thank you for attending this morning. I invite you to make brief opening remarks.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, Mr Cameron, and good morning to you and your fellow committee members. I am grateful for the opportunity to update the committee on the progress of our national vaccination programme.

Scotland's Covid-19 vaccination programme is delivering ahead of our expectations. That is thanks to the enormous efforts of our national and local vaccination teams, our local authority and third sector partners, the armed forces, and all those who have come forward for their jags. At the outset, I put on record my sincere thanks to each and every one of those people.

I want to update members, because constraints in vaccine supply will mean that, from this weekend, we will have to slow down delivery for a period. Let me explain that before we go further.

Our total receipt of doses to 7 February was around 196,000 less than expected and was therefore less than we had planned for in the deployment plan that we published in January. Alongside that, we have vaccinated around 75,000 more people than expected as a result of significant and very welcome take-up—of course, that side of the issue is good news, because it means that we have been getting the vaccine into more arms quickly.

Members will recall that Pfizer made clear publicly that its production would slow down so that it could be scaled up to meet global demand; therefore, the volume of supply for the UK is reduced for a limited period. If we take all that together and factor in the planned second doses, which will increase towards the end of February for Pfizer and in March for Oxford-AstraZeneca, we need to remodel our delivery to ensure that we carry enough supply to cover first doses and the increase in second doses.

We are on target to vaccinate 400,000 people this week, which is two weeks earlier than our commitment. However, to manage the reduced supply, from next week we will need to reduce the number of first doses to between 150,000 and 200,000 until supply increases, which we hope will be very soon. As I said, the supply issue affects the whole of the UK; it affects all four nations, and I continue to discuss it with my health secretary colleagues in the other countries. Of course, if supply increases sooner than we expect it to do, we will scale up. We have demonstrated that we have the infrastructure and the workforce to do just that.

My final point on that is that, notwithstanding the supply issues that I have set out, we will meet our target for the over-70s and the clinically extremely vulnerable by 15 February, and we will complete group 5 by the end of February/early March, as we said that we would do. We also still intend—supplies permitting—to be able to offer first doses to all JCVI priority groups by the end of May.

I would be happy to set out the detailed modelling and numbers, but members know that our colleagues in the UK Government have concerns about that, and that we are still to reach an agreement on which information can be published. People in Scotland are entitled to know about the vaccine that comes in and how quickly we are using it, and I intend to make that clear as soon as possible.

Given the focus of the meeting, I will provide an update on our progress in addressing vaccine hesitancy, particularly in ethnic minority communities. Finally, I will say a little about the global nature of the crisis and the global response that is required to meet it.

This week marks a significant milestone. The one millionth person in Scotland was vaccinated yesterday, which means that just over 22 per cent of the population has been vaccinated. The most recent figures show that 63,178 doses were administered yesterday, taking the total number of people vaccinated to 1,048,747. That means that we have vaccinated 99.9 per cent of elderly

residents in care homes, 94 per cent of all care home residents, 97 per cent of those aged 80 and over in the community, 87 per cent of those aged 75 to 79 and 54 per cent of those aged 70 to 74.

That has not been achieved without problems. I always said that there would be problems in a programme of such complexity, particularly when the programme must deal with variation in the vaccine supply and is, as we have seen recently, subject to the unpredictability of our Scottish weather. We must respond to those problems and resolve them.

Our decision at the outset to prioritise vaccinating older care home residents and staff came at a cost in terms of the overall number of people vaccinated, but it was the right decision because it saved lives. By mid-February, once everyone over 70 and those with a serious clinical vulnerability have been vaccinated, we will have to start conserving supplies in order to begin offering second doses.

We know that vaccine-hesitant people tend to come from the black, black British, Pakistani and Bangladeshi groups, or are likely to be people who have lower incomes or live in areas of deprivation. A report that was published by the scientific advisory group for emergencies in December 2020 showed that willingness to take a Covid-19 vaccine is markedly lower among Pakistani people and black ethnic groups. We are working hard to mitigate vaccine hesitancy. The Scottish Government is working with community groups and faith leaders to promote vaccine confidence and increase uptake, and we fund a number of community programmes. That work will continue at pace. I had the opportunity to hear what those on the previous panel said about the issue, and I look forward to hearing members' thoughts on it.

Finally, let me mention the importance of international co-operation. We are faced with an unprecedented global crisis that has left no country or people unaffected. It has emphasised the importance of our commitment to international solidarity and of working together on a shared challenge. It is essential to create conditions for equitable access to Covid-19 vaccines. That is why I am pleased that Scotland is part of COVAX, the international effort to reach out to other countries and act as good global citizens as we work together to find our way out of the pandemic.

As I am sure you heard from Grant Archibald, each health board is working hard to get the vaccine into people's arms as quickly as possible and as soon as supplies arrive. Everyone who is eligible will be offered the vaccine as we work our way through the priority groups. That work relies on partnership and collaboration with individuals and communities at all levels, which I am sure will be a theme in our discussion. I am grateful to all our partners, including those from whom you have heard today, for their engagement and support. I look forward to continuing that work and to seeing this important national vaccination programme through to a successful conclusion.

11:15

The Convener: Thank you very much for that very full and comprehensive overview of and update on the various issues.

I seek clarification on the variation of supplies, which you touched on at the beginning. I think you said that, because of that, you did not expect to meet your target dates for February. Where do you think that the effect of that restriction will occur? What impact will that have on the roll-out?

Jeane Freeman: To be clear, I said that we would meet our target dates for February. We can say that we have successfully completed the vaccination of cohorts 1 and 2. By 15 February, we will have undertaken the vaccination of cohorts 3 and 4, and we will finish cohort 5 by the end of February or early March, as I have previously said.

We are having to remodel because we also have to take account of second doses. We always would have done that, but lower supply in the immediate period means that we will not roll out the vaccine to group 6 as quickly as we had originally intended. However, we will roll out the vaccine to group 6. If the supply alters and the dip is less than we anticipate that it will be, we have shown that we have the infrastructure to move very fast and increase the number of people that we vaccinate but, right now, in order to take account of a dip in vaccine supply—which will right itself later—and the importance of second doses, we will slow down the roll-out of the vaccine to group 6, which we would otherwise have planned to get to very quickly. If we had been able to continue to administer 400,000 doses a week, we would have got there more quickly but, as we must scale back, that needs to slow down.

The Convener: Thank you. That is exactly the clarification that I sought.

Willie Rennie: Cabinet secretary, I want to thank you for responding so positively to and seeking to resolve the problems in Fife on Monday, and for apologising for the distress that they caused.

There are two parts to my question, the first of which is about the booking system. I am receiving reports from not just Fife but elsewhere that the booking system seems to be sending out invitations to more people to come for their vaccination than there is capacity in the centres. We have had that in Fife, which might be a hangover from Monday, but I have heard that that

has also been the case in places such as Cumbernauld and South Lanarkshire, where too many people seem to have been booked for the capacity of the centres.

Secondly, I understood that the over-65s were to be done by the middle of February, not the end of February. That is certainly the information that I had received through the official channels. I seek clarification of whether that was the deadline and it has shifted or whether, as you said, it was always planned that the over-65s would be done by the end of this month.

Jeane Freeman: I will answer your second question first. I am on record as saying that we would aim to complete the vaccination of the over-65s—group 5—by the end of February or early March. Of course, if next week we could go at the pace at which we have gone this week, we would get there more quickly, but the supply issue means that we cannot. That has always been our position.

On your question about the booking system, I would be happy to ask Caroline Lamb to explain some of the issues around that. There is real value to having a national booking portal alongside the national vaccine management tool. Notwithstanding the glitches that need to be resolved as we go, we are creating a legacy vaccination infrastructure. We are doing that on the simple premise, which I think is a sensible one, that, notwithstanding the current programme to get through 4.45 million or 4.5 million adults over 18, we have a reasonable expectation that vaccination for Covid will be a continuing exercise. We do not know what the scale of it will be in future years or the number of years for which we might do that; Professor Leitch might want to say a bit more about that. However, it is reasonable to expect that some kind of Covid vaccination programme will be required, so creating those national tools is an important part of the infrastructure.

Caroline Lamb will say a bit more about the booking system.

Caroline Lamb (NHS Scotland): We are aware of the issue in NHS Fife and we are very sorry that it happened. It has been identified as an IT glitch in the system, we have confirmed that it did not affect any other NHS boards, and it has been fixed.

One of the things about standing up a national booking system is that it works by using assumptions about how long it takes to get vaccinations done through clinics. We are learning all the time about the processes, and some clinics have only newly started to operate. I am not aware of systematic issues in other health boards, but there may have been issues in individual clinics because of the assumptions in the system about how long each appointment would take. NHS boards are working through that sort of issue locally and updating the system. We are learning all the time about how that works.

I will add to what the cabinet secretary said about the legacy and the opportunities provided by standing up a national system. At the moment, in boards that are using the national scheduling tool, we are moving towards giving people who are booked in for appointments the ability to use the tool to reschedule their appointment—they are also able to phone the helpline to get help with that. As the cabinet secretary said, we are running a lot of people through clinics this week so availability for rescheduling appointments will be pretty tight, but that will ease off as we go forward into future weeks.

The other thing to make clear is that the tool is being developed further. As we move into broader groups of the population, we expect them to be able to schedule their own appointments and choose the location that is most convenient to them, which might be a location closer to where they work rather than to where they live. The system is being developed all the time, very much with an eye to the future and what we will need to do around continuing programmes of Covid-19 vaccination and our vaccination and immunisation programmes more widely.

Willie Rennie: I think that there is a sizeable problem. People who are over 80 and were vaccinated by their GP are now getting letters from the central system offering them another appointment for the first vaccine. Will that problem be resolved? It could lead to—[*Inaudible.*]—unused appointments if people do not cancel them. Is that a widespread problem?

Caroline Lamb: I am aware of some issues, particularly around St Andrews, where there were some instances of over-80s who had been vaccinated being offered new appointments. Again, it is about making sure that all our data is linked up. The team has been working hard to resolve that, so we would not expect to see it happening in the future.

There is a complexity about people appearing in more than one cohort, and we will see more of that as we go through the programme. Teams are working hard to address that, because when we get to the over-50s a number will already have been vaccinated by virtue of being health and social care front-line workers, for example. There is a huge amount of logistical complexity to be dealt with in the programme and we will not get everything right first time. However, we are working hard to learn from the things that do not go quite right to make sure that we get them right for the future.

The Convener: Our next set of questions is on vaccine procurement and distribution and the deployment plan.

Annabelle Ewing: My first question is for the cabinet secretary. Again, I praise the Herculean efforts—that is how they have been described, and that description is absolutely true—of everybody involved in ensuring that the number of those who have received their first dose is now well over the 1 million mark.

I want to go back to the issue of supply. Do you have any indication at all of when you will be able to provide a timeline for the roll-out that might be impacted by the gap in supply to the UK? Obviously, people who are listening to this will want to have as much information as is currently possible.

Jeane Freeman: I would like to make a point in response to the issue that Mr Rennie raised before I answer Ms Ewing's question. It is a point about data linkages, which Caroline Lamb touched on.

One of the issues that we are resolving as we go is the difference between the data that comes in through our national vaccination management tool and the data that comes from GPs through their own system. Ideally, we would want everyone to be on the national vaccination management tool, not least because it gives us very clear sight nationally of the numbers going through and the forward bookings, so we can look ahead in a much better way. I hope that we will get to the point at which everyone is on that tool, as that also gives us downloaded data every two hours, I think—Caroline Lamb will correct me if I am wrong. We can therefore see how the programme is working. If we foresee or anticipate glitches or issues, we can then act a bit more quickly to resolve them.

The other point that I want to make to Mr Rennie and, indeed, all colleagues is that, if issues are raised with them, the best thing to do is to ensure that we are aware of them so that we can act quickly. Even if there are only one or two instances, we still want to know so that we can act quickly to resolve them.

Ms Ewing's question is really important. It is important for everyone who is listening and members' constituents to know that, notwithstanding the dip in supply that we know that we will have next week and the week after, we will still meet the 15 February target and the target to complete group 5 by the end of February to early March, and that, towards the end of February and into March, we will begin to issue in a phased way booking appointments for group 6, which is among the most complex groups. People in group 5 should not be anxious that the appointments that they expected to see through the rest of February will not come. We are slowing down from 400,000 doses a week—giving that number would have meant our getting through all the doses much quicker—to around half of that number. That will allow us to do what we have said that we will do—we cannot go faster than that—and to begin to model in and hold doses for second doses. We should not forget the critical importance of second doses, which complete the programme. Professor Leitch might want to say a bit about that.

On the numbers that we can publish, Ms Ewing and other colleagues will be well aware of what we published on 13 January and then took down. We published our deployment plan minus those numbers on 14 January. I am still in discussion with my colleagues in the rest of the UK about what we can publish. I want to be able to publish not future supplies, because I understand the contractual sensitivities around them—as we see, they change—but the doses that came into Scotland and what we are doing with them so that people can see that, as I have always said, we are moving fast to get doses that arrive in Scotland into people's arms and that we have improved the overall distribution system in Scotland so that we have a national approach in addition to the local one.

The national approach is there to supplement if a particular area needs more than it had originally planned for because it has had greater uptake than expected. That is where we are on all of that, but Professor Leitch might want to say a bit more, just so that we are all clear about the criticality of those second doses.

11:30

Professor Jason Leitch (Scottish Government): Good morning to the convener and the committee—thank you for having me back. Unusually, I do not have much to say. The second dose gives people slightly better protection—a few percentage points—and, crucially, longer protection. Since we spoke last week, the research that AstraZeneca has published has been very important for our understanding of the 12-week gap. It has further reinforced the evidence behind that 12-week gap being the right choice and the JCVI being correct. It now seems as though people get about 70 per cent protection and maybe even reduced transmission from that first dose and then the second dose gives people longer protection.

However, it is important that we still do those second doses. The second dose does not have to be exactly 12 weeks after the first dose, so if people get it 11 weeks later or 12 weeks and one day later, they should not panic. We will give a bit of leeway for care home residents to go first to get that in. As the cabinet secretary says, it is absolutely crucial that those second doses take

priority. That is exactly what I said a week ago, but the newspapers made it sound as though I was slowing down the whole process. That was not the intention, but we will slow the first dose numbers in order to allow those second doses to be done.

Annabelle Ewing: It is really important for those of our constituents who have had their first dose or will have had their first dose in the next weeks to know that their second dose will be administered timeously, so I thank the cabinet secretary and Professor Leitch for that helpful clarification.

I have one brief question for Professor Leitch. Do we have any indication as to when the Moderna vaccine might be approved?

Professor Leitch: Phase 3 trials are completing; the company and the Medicines and Healthcare products Regulatory Agency think that the vaccine will probably be approved in April, but we cannot really feed it into our Excel spreadsheets until we know. A number of steps have to be gone through.

We have no reason to believe that the vaccine will not go through the same processes in the same way as the previous vaccines, but we have to be careful. The company has to prove the quality, safety and efficacy of the vaccine. There is a three-step process to show that it has done those three things. The best guess is that the vaccine will be approved in April.

Remember, before we get overexcited, that the UK was a little bit later in buying Moderna than some other countries because Moderna was faster than anticipated. Therefore, we do not have hundreds of millions of doses of Moderna on order. However, we do have tens of millions of doses on order for the whole country and we will get some of them. That will help us as we move into those targets that the cabinet secretary just spoke about for May and then into the big population level of below 50-year-olds as we move into the summer.

The Convener: We have a couple of supplementaries on general vaccine policy. The first is from Stuart McMillan.

Stuart McMillan: Cabinet secretary, you were very clear about the supply issues over the next couple of weeks, and your explanation as to why there are supply issues was also clear. Can you clarify what the situation will be after the next two weeks and whether the supply will go back up to what was proposed?

Jeane Freeman: I will bring in Caroline Lamb on that after I make two points. The first partly finishes off the second dose question, and it is relevant here. We have made a really clear, clinically supported commitment that people's second dose will be the same vaccine as their first dose. Even if supply numbers increase from what we expect in the next two weeks, so, too, will the number of second doses.

We should remember that the first vaccine that we used, for about a month, was the Pfizer one. We used it for the first two groups—elderly care home residents and care home staff, and health and social care staff. Therefore, even if we got a boatload of Pfizer tomorrow, we would need to hold a significant proportion of that to be able to meet the second dose commitment and ensure that, if someone's first dose was Pfizer, their second dose will be Pfizer.

We have touched on that issue before, but we are now up against it. We are now running two vaccine streams. The second doses have to be the same as the first doses, and we also have new first doses. That adds a little to the complexity of managing the programme and managing stock so that it can be distributed fairly across the country and we can get the right vaccine to the right places for the right people.

On whether we expect that the dip in the weeks beginning 15 and 22 February will ease, I will ask Caroline Lamb to say a bit about that in a moment. Again, we have touched on the issues before. We and others, including the manufacturers, have said that supply is lumpy in the way that it comes out of the manufacturing process. Anyone who has experience of manufacturing will understand that. If you are manufacturing something brand new or scaling something up, things will happen that you did not anticipate, and that will mean that your output is not necessarily as even and smooth as you expect it to be in a month's or a year's time.

What we think will happen three, four or five weeks from now has to be an estimate at this point, until we have confirmation. We absolutely need confirmation to be able book people in so that we avoid some of the issues that colleagues have raised about either running empty, where we have the vaccine but we have not booked in enough people, or running hot, where we have booked in too many people for the vaccine that we have. We need to practically eyeball the actual doses to be certain before we can start booking.

Caroline Lamb is much more engaged than I am in the detail of that every single day, so she will have more to say.

Caroline Lamb: We have a particularly tight period for the next two weeks. For the weeks commencing 15 February and 22 February, our supplies are pretty low. After that, we expect supplies to increase, for the reasons that the cabinet secretary has set out. I cannot be absolutely open with you about precisely what we are expecting but, based on current projections,

we will then see another dip, just for a week, towards the end of March.

To be clear and to reinforce what the cabinet secretary said, we get regular updates on what we can expect our supply to be, and those updates move quite a bit. Therefore, we need to be careful not to make assumptions about supply three or four weeks from now that might not materialise. In broad terms, however, the situation will be really tight until the end of February, it will get a bit easier through March and then will dip again in March.

I also highlight what the cabinet secretary said about second doses. It is really important that, in our reporting, we start to report the number of first doses and second doses that we are giving, because that is the real measure of the total consumption of our vaccine supply.

Stuart McMillan: I have one brief question, just for absolute clarity. Are the supply issues that we are about to go through to do with the Pfizer vaccine, which is manufactured in Brussels?

Jeane Freeman: The issues are twofold, actually. Pfizer was very open about the fact that, in order to meet global demand, it would need to scale up its production. To do that, it has to scale down to get the new machines in and the new lines of production running—it is no different from manufacturing anything else—and that causes that dip. As I understand it—Caroline Lamb will correct me if I am wrong—AstraZeneca is moving to production for the UK solely in the UK, so the factory in Wales will be the sole provider for us. Therefore, there is movement.

None of that should be taken as criticism of the manufacturers. They are working hard to increase their production because this is a global pandemic and other countries need and should have the vaccines too.

The vaccines are at an early stage of production. It is not the same as a supermarket ordering today the number of loaves that it expects to need tomorrow from its supplier, which has been producing those loaves for years. Barring something going wrong, such as a machine breaking down or a fire happening—I would not wish that to happen—if the supermarket orders 1,000 loaves, it will get 1,000 loaves. This is not as smooth as that process yet, because it is a new manufacturing process and therefore supply comes out a bit more lumpily, as we described before.

The Convener: David Stewart has a supplementary question.

David Stewart: Johnson & Johnson has had a single-dose vaccine approved in the States, which, if approved in the UK and beyond, would presumably save a lot of logistics headaches. I note that the Russian vaccine, Sputnik V, has a 92 per cent efficacy rate and has just been approved for use in Hungary—it is one of the first EU nations to have it. Where are we on approval in the UK? What is Jason Leitch's view on both those vaccines?

Professor Leitch: Let us think about the process. I do not think that the Janssen vaccine, which is the Johnson & Johnson one, has been approved in the US. A trial has been published, but I do not think that the Food and Drug Administration has approved it. It is the first single-dose vaccine in the pipeline, and there must be trials to establish whether that gives us enough protection.

A couple of people have asked whether a vaccine will be needed annually. At least for the foreseeable future, we think that we will probably all need a booster dose of a vaccine that will react to and be adapted to new variants.

The MHRA will be in conversations with all these companies. We must remember that companies must apply for approval. The MHRA does not go looking for them; the companies go to the European, US and UK approvers and ask for their vaccines to be approved. It is in the companies' interest to do that, because they want to sell their vaccines. There is a pipeline of companies going to the MHRA, as the trials come through. After phase 3 trials and, uniquely for this purpose, during phase 3 trials, they apply for approval, pending the results.

The efficacy rate of more than 90 per cent for the Russian Sputnik vaccine is excellent news. That is in phase 3 trials—it is not in the wild, but in the limited cohort. The MHRA will look at that data—the age distribution, the demographic distribution and the ethnicity distribution—and decide whether that efficacy rate is correct for our population, and then it will take a view on whether it should be approved for use in the UK. The UK Government, on behalf of us all, has put poker chips on some of those vaccines coming good, which is why we have 360 million doses ordered that are not all here—they are not even all approved yet. We are as confident as we can be that we have bet on the right vaccines to come through that pipeline.

11:45

Mark Ruskell: I turn to the problems that we saw in Fife this week. Is there now absolute clarity about the nature of the IT glitch in the move to the national booking system? With regard to health boards such as NHS Tayside that have yet to transition to the national system, can the cabinet secretary reassure us that she can learn lessons

very quickly from this week's incidents so that the problem can be avoided in the future?

Jeane Freeman: I will ask Caroline Lamb to explain some of that in a bit more detail. As Caroline said, the problem has been identified and is being fixed. As far as we know—and we would know by now if this was not the case—the problem did not affect other boards that are in the process of transitioning.

That said, we cannot guarantee that there will not be different glitches—I know that you understand that. What is critical for me, as the cabinet secretary, is that when a problem arises, we fight it as quickly as possible. We act to fix it and mitigate any consequences. Those are the two key things that we did with NHS Fife.

That does not diminish the upset and, in the case of Fife, the distress caused to many people. However, the important thing is the speed with which we respond in circumstances where we cannot sensibly give any guarantee that we will never hit a problem.

Caroline can say a bit more about the specifics of the IT issue that affected Fife.

Caroline Lamb: The issue that affected Fife has been identified and a fix has been applied to the system. We are confident that it will not recur.

Boards are all learning very quickly about how to use the system, but other issues will arise. As the cabinet secretary said, the important thing is that we and the system are made aware of issues once they arise. In Scotland, we have the advantage of being able to rapidly communicate around our 14 territorial health boards and share information quickly among the people who are involved on the ground.

There are two things to consider. One is IT glitches in the system, which is what caused the issue in Fife. The other is how users use a new system and become familiar with it, and it is important that we share knowledge, understanding and learning from that, so that we can very clear that the system is being used in the same way by all our NHS boards and that we are getting the results that we expect.

We have a really good team working on all of that, and they are working their way through the issues that arise, with a view to having a system that works as well as it possibly can. The lessons that have been learned from the experiences of the first seven boards that went on to the system will absolutely be shared as new boards come on to it.

The Convener: Mark, do you have a follow-up question on that?

Mark Ruskell: I have a question on another topic. Would it be useful to ask it now?

The Convener: Is it on vaccine hesitancy?

Mark Ruskell: It is not, but I could move on to that topic if you wish.

The Convener: Ask your question first; we can deal with vaccine hesitancy in a moment or two.

Mark Ruskell: We have had some worrying information this morning about the numbers of different variants in the UK and the approach that we are seeing, particularly in other parts of the UK, to surge testing. Can you give us an update on how that is playing out in Scotland? I am thinking about two issues. The first relates to geographical areas such as Clackmannanshire, where there is still quite a high rate of infection. The second relates to the outbreaks that we are seeing in workplaces—there was an outbreak in Perthshire and one at a bus station in Stirling. How do you use surge testing in geographical areas and in workplaces? Do you test those who are symptomatic and those who are asymptomatic, and then go on to do sequencing, to ensure that we have a hold on where the variants are cropping up? I would appreciate an update on where we are with that, because I am hearing of progress south of the border but am not clear on what is happening in Scotland.

Jeane Freeman: I will start, convener, and will come to Professor Leitch for more detailed information on the issues around variants of the virus.

The dominant virus now in Scotland is what was initially known as the Kent variant. That is the one that we are dealing with primarily at this point. The old virus, if you like—the one that we had at the start of last year—is much diminished, and the new one is much more infectious. The nature of what we are dealing with determines how we use the tools that are at our disposal, of course—that just makes sense.

I think that Mr Ruskell is largely referring to community testing. He will have heard information from the First Minister on a couple of occasions about the increase in community testing that is now under way. We already have testing for all admissions to our hospital settings and for our patient-facing health and social care staff, and we now have testing three times a week in our care homes as well as community testing.

Before Christmas, we ran some community-based asymptomatic testing, and we are now scaling that up in two ways. The first is based on discussions with the local authority about what makes the most sense in its area. We look at the data and then work with the local authority so that it can run the testing, for which we supply the kit,

and then the information comes into our database. The armed forces are helping us a little in setting up some of that, and of course the Scottish Ambulance Service is really critical.

Secondly, we do community testing in areas of critical importance to the country in which work cannot be done at home, so those who work in those areas have to come together. Even with good mitigation measures in the workplace setting of 2m distancing and all the rest of it, their being together means that the risk of transmission is higher. Initially, that has involved food processing and production. Discussions are going on with employers to make sure that they encourage their workforce to come forward to be tested so that, if someone is asymptomatic but has the virus, we can quickly identify them, prevent the spread, support them to self-isolate and deal with any clinical needs and so on.

Those are the two main extensions of community testing. I am happy to check this and let the committee know if I am wrong, but from memory I think that we have agreements now for local authority partnership testing in 17 of our local authority areas, and, as I said, the work is under way in the food processing sector.

As we continue with that testing—and our supply of testing kit and our capacity for processing polymerase chain reaction testing have obviously increased considerably—we will, with colleagues, begin to look at other areas of the economy and other sectors where testing may make sense. Of course, we have a significant increase in testing in our schools, in order to be ready for the first phase of their return. As the return increases in due course, that will increase across schools.

Professor Leitch might want to say a bit about variants—how we identify a variant and what we then do about that.

Professor Leitch: I categorise the testing in a similar way to the way that the cabinet secretary has just described. We do routine symptomatic testing, which is well understood and which we have had for many months. We also do routine asymptomatic testing, which is expanding. Sometimes, that is to do with where people work, and sometimes it is to do with who they are or where they are, so it might involve students or care home workers.

We also do targeted testing, where it is required and where the public health leaders of the local community ask for it. Therefore, if there were an outbreak, we would send resources to allow that targeted testing to happen.

Surge testing is a slightly different concept, and one that they have used in England in the community testing for the South African variant. They have gone to the postcodes where there has been community transmission of that variant without travel. We do not have that situation. We have six cases of the South African variant—five confirmed and one possible—and in none of them has there been community transmission; they are all related to South African travel. We think that those cases are contained, because we can self-isolate those people in a much more serious way than we do conventionally.

We also think—unfortunately or fortunately, depending on where you land—that the Kent variant is helping us, because it appears to be dominating the South African variant. Even in England, the South African variant is not gaining huge traction, because it is transmission that gives a variant traction—that is, the one that wins the race is the one that transmits the quickest—and the Kent variant appears to be overwhelming the South African variant in that regard. Although the Kent variant is worse than the previous variant, we do not want the South African variant, because it is harder to find.

Presently, therefore, we do not need surge testing, which involves genomics, as that is the only way to find the South African variant. However, we have the resources available to do that if we need to. The UK-wide genomic collaboration can do that testing if we require it to be done.

That is where we are. We have testing in place for the variants that we have at the moment, and we have the potential to test for the South African variant.

The Convener: I would like to move on to the issue of vaccine hesitancy. Mark Ruskell and John Mason have questions on that.

Mark Ruskell: Thank you for the answers to those last questions. I think that moving the testing programme on to other workplaces will make a difference.

On vaccine hesitancy, you might have seen the answers that we got from our first panel of witnesses this morning. Do you have a clear handle on those sections of society where there is vaccine hesitancy, and how does that feed back into the strategy for the roll-out of the information and for the development of partnerships that are being developed locally to reach disadvantaged groups? Is there enough of an understanding of that issue, and is enough support being delivered through health boards to ensure that those groups are being targeted and supported?

Jeane Freeman: That is an important question. We need to understand that vaccine hesitancy arises in different groups for different reasons. We saw a slow uptake of the vaccine among care home staff. That was because they had been

targeted—I cannot think of a better word than that for it—by those who question whether we should be paying as much attention as we are to Covid-19 and do not believe in vaccination. The approach that those people took to care home workers was distressing for those workers, because it also questioned whether they were doing the right thing for the residents and those they care for. In other groups, there is vaccine hesitancy for reasons to do with their faith or something similar, and there are other people who, because of certain conditions that they have—anaphylaxis, allergies and so on—also have concerns. Therefore, we must respond to the issue in different ways.

Professor Leitch can say something about the approach that we took in relation to care home staff, which we will take with any group of staff. It simply involves being open and answering in person any concerns or questions that people have. That means that we can reassure people and give them information, so that they are better informed. Following that approach has led to a significant increase in the uptake in that group, so we will continue to do that.

12:00

My colleagues Shirley-Anne Somerville, Christina McKelvie and Aileen Campbell have all helped us significantly with regard to, for example, faith leaders. I think that you might have seen the little video that features a range of faith leaders in Scotland promoting the uptake of the vaccine, which is designed to ensure that the communities that they serve are well informed. Of course, we put out information in as many language and formats as necessary and, if we miss any, we can address that. We have worked with BEMIS and Sikh Sanjog and have provided specific resourcing to allow them to host webinars and do targeted campaigning among the groups that they represent.

I do not think that we have finished doing what we need to do—I am not telling you what we have done in order to let you know that we have done everything and we are now fine. We need to keep looking at the situation. As the data comes in, we are increasingly able to see where there might be clusters of people who are not taking up the vaccine to the same extent as it is being taken up across the country or more widely in their community. That might involve people who are in disadvantaged communities and are not regularly in contact with their health service, perhaps because they do not find it easy to access those services. In those cases, we will have to modify our approach to delivering the vaccine in order to make it easier for them. However, the data coming through is what allows us to take a geographic view that enables us to see whether there are parts of the country or communities where the uptake is lower than elsewhere, so we can decide what to do about that.

The final thing that I will say on the issue is that we are looking ahead to the group of people who are over 18 and under 50, and we are trying, through our insights team, focus groups and so on, to get an idea of how they are feeling about taking the vaccine and what the likely uptake might be. If we think that the uptake in that group might be lower than we would like it to be, we will need to change our approach to marketing and the dissemination of information so that we encourage people in that group to take the vaccine, too. We are aiming for an 80 per cent uptake—that would be good; higher would be better—and we will need to modify our approaches as we work through all those groups.

Professor Leitch or Caroline Lamb might want to add something.

Professor Leitch: Apologies for the delay; I was just waiting to be unmuted—it is a horrible power that someone has over me, which I dislike.

Quite a lot is now known about the issue that you ask about, Mr Ruskell. There is an excellent initiative called the Vaccine Confidence Project, and, along with the UK's senior clinicians, I had the privilege of meeting its leader on Tuesday night. We had a UK-wide discussion with all the chief medical officers, clinical directors and chief nursing officers about how to tackle the issue across the country.

The first thing to say is that we should keep the issue in perspective—I am not saying that it is not important, but we should view it in the context of other issues. We have managed to vaccinate well over 90 per cent of each of the groups that we have so far targeted. That is much higher than any of us anticipated. However, 99 per cent would be even better, so we should keep at it.

There are four categories of decision-making and communication difficulty. There is an age-related challenge, which the cabinet secretary has just talked about. In that regard, we are in conversation with Young Scot and schools. Just yesterday, for example, I did some work with primary kids, to try to get them to persuade their parents to get the vaccine.

There is also a demographic challenge. In general terms, the poorer you are, the more hesitant you are about getting the vaccine. Of course, that is not universal. In general terms, the issue is about access, so we have to make it easy for people to get the vaccine. That involves taking a GP-led approach in some places and not in others.

There is an ethnicity challenge which, in some ways, is mixed in with a faith challenge. We have done quite a lot of work with faith leaders over the past couple of weeks and I was with faith leaders again yesterday. One of the outcomes—members will have seen this—was the little video from all our main faith leaders that went out on social media in the past couple of days.

The issues are partly about the vaccines' constituents, partly about state control and partly about where the vaccines come from. We have to communicate those issues specifically, for each ethnic group—and we have tried to do that.

There are some surprising ethnicity challenges. Quite a lot of the anti-vax community are eastern Europeans. The eastern European news is much more anti-vax than the UK news, and quite a lot of eastern Europeans who live in the UK get their news from their original country—of course, just as we would do if we were living in Japan or Australia. We have to combat that issue specifically, in schools, among parents, and among elderly people in care homes who happen to be of that ethnicity.

Finally, there is the issue that the cab sec mentioned at the start, which is workplace. That is an issue because people have been targeted; the challenge is to do with not the individuals but the information that those individuals have been given by people who I suggest are, at some level, undermining the vaccine programme and causing harm.

The Vaccine Confidence Project people's summary of the long conversation in that regard was that we need to surround each of those groups with the correct, evidence-based information. That is what we are trying to do, with marketing colleagues and through me, talking to people—unfortunately for them—including care home workers, as I have been doing. This week, I have been talking to home care workers, and hundreds of people have been asking questions. We have to use the media, we have to use trusted voices and we have to use MSPs to get to each of those groups.

Caroline Lamb: All the messaging and engagement with groups is really important. The other side of the issue is the data and our ability to analyse it, so that we know which groups we are not hitting and which locations do not have high take-up. [*Inaudible*.] It is about getting to all communities and maximising uptake. If we find that we need to use mobile units to go to particular locations, that is absolutely what we will do to ensure that uptake is as high as it can be.

The Convener: The next questions are from John Mason.

John Mason: Convener, Mark Ruskell has covered the issues that I was going to ask about.

The Convener: Thank you, John. I will bring in Maurice Corry.

Maurice Corry: Good morning to the witnesses, and I thank you guys for all the work that you are doing on the vaccine roll-out.

Caroline Lamb, do you think that there are gaps in your communications programme? Are there blue-sky objectives that you would like to have but do not currently have, which would make the whole programme even more successful and effective?

Caroline Lamb: What is very important is that we are clear and consistent in our messaging to the public. So far, people have been very anxious to get their appointments, which is great, because it indicates people's enthusiasm for getting the vaccine. The feedback that we get from the vaccination centres is that there is a very positive atmosphere and people are getting a real buzz out of being involved in the programme.

We will need to start to tilt the messaging more towards the importance of people taking up the vaccine not just for their own protection but so that we provide greater protection for everybody.

We also need to be careful about the messaging about what additional freedoms vaccination affords people . It is absolutely clear that a person's having been vaccinated does not mean that they do not need to stick to the guidance and comply with the regulations. Jason Leitch might want to add to that.

Professor Leitch: That is exactly what I was going to say, Mr Corry. I think that this phase of the communication has gone very well. People are excited to be vaccinated, which is new, and that is testament to the public and our marketing department. I should put on record the astonishing work that it has done, working round the clock for a year on television adverts, newspaper pull-outs and everything else that you would expect. However, the next phase of the marketing must be carefully done, because we are not yet at the point where the vaccine can change behaviour—which will be an interesting and challenging transition for people—because the prevalence is still too high. We have not talked much today about the pandemic in the round, but the prevalence is still too high and it will take us more time to get to the point where we open up more. The Cabinet will decide next week whether it still wishes to use the 22 February date for schools, but we have made very clear that, after that, it will be baby steps.

Maurice Corry: Good. How are you getting on with my proposal of five points to ease

communication, which you were going to take back up the line?

Professor Leitch: I sent that to marketing and I can check to see whether it came back intact. If you see it in some kind of marketing material, I—not you—will take the credit, clearly. [*Laughter.*]

Maurice Corry: All right—we will sort that one out. That is good; something is going to happen on that.

Professor Leitch: Yes.

Jeane Freeman: I will make two points on that. Mr Corry and all colleague MSPs are also significant communicators, which is why I am keen that we give you as much clear information as possible. Many of you have newspaper columns in your local press—perhaps weekly or less often—and if you have not already done so, it would be helpful if you could use those to encourage people to take up the vaccine. However, as Caroline Lamb said, it is also about being clear on what the vaccine does and does not do; we understand the protection that it offers to people as individuals, but we are not yet certain that it prevents transmission in any respect and that is why all those other points are so important.

The other point that I will make for Mr Ruskell and colleagues is that I have just seen a tweet from the Al-Amal project in Grampian pointing out that its vaccination champions for the new Scots Syrian, Iraqi and Palestinian refugee community have been vaccinated—in the right cohorts, of course. Using local champions from those groups to communicate, answer people's questions and promote vaccination take-up is another way that our local boards and authorities are tackling vaccine hesitancy .

The Convener: Thank you for that information. Maurice Corry would like to come back with one question.

Maurice Corry: My apologies, cabinet secretary; I meant to ask you a similar question. As before, my question was premised on the fact that I am getting a lot of feedback from community councils, which I visit in Zoom meetings, and they are keen and anxious for information to be distilled down through them. We were talking about the five key points that would be processed from the Scottish Government and local authorities down to community councils, and that is the part that we play as MSPs.

Jeane Freeman: Yes; for example, last week, I issued information to you that had a breakdown of all the vaccination centres. That is useful information for community councils to have, so that they can promote it in their newsletters. Anything else that comes out from me to you is there for you to use; it is for your information but also for you to use in whatever way you think is most helpful in your local area.

Maurice Corry: Thank you.

The Convener: We move next to the theme of international distribution.

John Mason: Before I come on to that, I will ask about quarantine, because we have not really touched on that today. Once managed quarantine comes into play, I understand that the testing of people in those facilities will take place after two days and eight days. Will one of the witnesses expand on what the testing will involve?

12:15

Jeane Freeman: That is an important question. Our colleagues in the overall testing programme are busy working on that. I expect it to be a mix of PCR and lateral flow tests—I do not think that that has been finally confirmed yet. PCR tests are, of course, the better of the two, because that method has higher efficacy. I expect that that would involve individuals using the home testing kits, so they would do the tests themselves, under supervision. The tests would then be processed either through the Lighthouse lab or our own new NHS hub laboratories. I am happy to pull together the detail and get it to Mr Mason and other committee members.

John Mason: That is great—thanks.

The main issue that I want to ask about is the international aspect. We heard that only one of the 31 poorest countries in the world has started vaccinating. That concerns me. I realise that some of this will be dealt with at UK level, but does Scotland have any opportunity to do or say anything about the issue? We have links with countries such as Malawi. Are we able to help it? Can we exchange information, as I know that we do in normal times?

Jeane Freeman: That is an important question. Again, Professor Leitch might want to say a bit more about that. Mr Mason is right. We have a number of international development partner countries—Malawi, Zambia, Rwanda and Pakistan. Our work to support those partner countries includes their Covid-19 responses.

Last September, we reviewed our approach on international development and ring fenced £2 million of our international development fund to support Covid responses. We work through UNICEF in order to meet each country's needs, including the supply of clean water, sanitation, hygiene, child protection and so on. Our support in response to Covid includes helping to prepare their health systems for the distribution of the vaccine. Colleagues in the international division will be able to update members on how that work

is going. That is just one part of our support for an international response.

There are two linked areas of thinking that would support such action. First, we are citizens of the world and we should be good global citizens. Secondly, none of us gets out of this unless everyone gets out of this. That applies not only across the four nations of the UK but internationally. We need the world to be able to deal with the pandemic and get all populations to be as safe from the virus as we want our Scottish population to be. There is a great deal to commend about the work that we are doing, and we are engaged with the UK Government to see whether more can be done.

There are other areas of international co-operation, including in research, science, epidemiology and so on. Perhaps Professor Leitch will want to say a little bit about some of that.

Professor Leitch: It is a crucial question. COVAX is the global response to the pandemic. The aim is to vaccinate 20 per cent of the population of the 92 poorest countries in the world by the end of 2021. The donors to the programme are the main World Health Organization donors. The UK is at the top of the league table. Fortunately—I mean this apolitically—the US has rejoined the WHO. That will not only help financially, but help in terms of scientific and academic resource. At an individual country level, the UK is fully engaged in that through international development and the departments of health around the country.

At a Scottish level, there is some resource. Principally, there is help through our ability to liaise with the people we already know. I am planning a call with the heads of quality in Zambia and Malawi, who I know for other reasons from non-pandemic times. I was in a meeting that the WHO convened the week before last on how we would engage in an intellectual way, rather than a monetary way, to help Malawi and Zambia with their roll-outs—on lessons learned and ascertaining what they need. We do not want to impose our version on them, but is there anything that we can do to help them?

That is an on-going relationship, which usually concerns maternity safety or mental health waiting times, for instance, but we will engage on vaccination in particular, because that is the top priority in those countries right now. Those relationships are good, they are intact and they will be used for that purpose.

At a high level politically, the Scottish Government supports the COVAX programme, and I would encourage every MSP to get behind that on behalf of the Scottish Government and also the UK Government.

John Mason: That sounds quite positive from a Government and health point of view. What about pressure on the companies? With HIV, the big pharmaceutical companies were forced to share their knowledge around the world, which helped us to get on top of the condition. Is there any sign of that happening and that the big companies will be forced to share their intellectual property and general know-how with Africa, Asia and so on?

Professor Leitch: I can take that question, cabinet secretary.

Jeane Freeman: Please do.

Professor Leitch: I would not use the word “forced”; I would use the word “coalition”. The WHO is leading a coalition in partnership with private companies—it is, of course, private companies that make the vaccines—and with Governments, which help with the supply of the vaccines. For example, if Pfizer shares the intellectual property, we can give the vaccine formula to the biggest vaccine-manufacturing plant in the world, which is in India, and that factory can make the Pfizer vaccine. That is happening.

Pfizer is providing the vaccine at cost, not for profit. All the drug companies that I have looked at so far that have vaccine in the market—I have not seen them all—are saying that they will give vaccine to COVAX at cost price and will allow it to be manufactured in those safe and effective factories in those parts of the world where it is needed. There are a billion people in India, remember; they need 2 billion doses of vaccine. That puts our vaccine programme in perspective when we think about the need to vaccinate rural India and sub-Saharan Africa.

As far as I can tell—and there are cleverer people than me checking and looking at this—the drug companies are absolutely engaged in the global response, and they want that to be part of their legacy.

Jeane Freeman: Oxford-AstraZeneca set out very early what international approach it wanted to take. The First Minister and I have regular meetings—either together, or I will have a meeting—with both Oxford-AstraZeneca and Pfizer, and we will use those opportunities to continue to encourage those firms to do just what has been described. As other vaccines come on stream in the UK and in Scotland, we would look to have the same kind of relationship with the other companies concerned as we currently have with Oxford-AstraZeneca and Pfizer. That includes Moderna, whose vaccine we expect to come soonest.

The Convener: Willie Coffey has a question on this topic. Please feel free to go straight into the next topic, on longer-term issues, after these questions and answers.

Willie Coffey: First, I apologise, as my data connection is dropping with regularity. Hopefully, it will stay on during this question, which is for Jeane Freeman. It is about the international dimension, which you mentioned in your opening remarks and a few times in response to members' questions. I had been hoping to ask similar questions to representatives from the UK vaccine task force but, sadly, they declined the invitation to come before the committee.

My question follows on from John Mason's earlier one to you. Can we reasonably expect third-world countries—our friends—to vaccinate at the same pace that we are able to in the west and in Europe? If so, do those countries need more help to enable them to do that? The issue is not about vaccine supply, but about the distribution and application methodology. Do you think that we need to help them more in that regard?

Jeane Freeman: That is an important question, as was Mr Mason's. You are right that is it not only about the supply of vaccine, but about getting it into people's arms as quickly as we can. I touched on that in part when I spoke about the ring-fenced money that we put aside to help our international development partners with their Covid response. That is about the infrastructure and support to deliver a Covid response.

I would not want to do anyone a disservice, but it is not likely that they will be able to do it across the piece at the pace that we can. That is partly due to the sheer scale and size of those places. You heard Jason Leitch talk about the number of people in India, for example. It is also about the existing infrastructure in those countries, including their health infrastructure and the other bits of infrastructure that are needed, such as road and rail networks, to access to remote and rural communities.

Personally, I have no doubt that more help and support are needed, and I know that we would want to play our part in that, so we continue to press for that to be the UK-wide response. Professor Leitch might have a bit more to say on that, given his more detailed knowledge of some of those countries.

Professor Leitch: You have covered it well, cabinet secretary. Of course, it is not only about getting the vaccine to a country; it is about distribution and all the other issues that we have faced in a very developed country with a very developed health system and a digital solution to data collection. We should be able to help other countries with the digital infrastructure and training materials that we have used across our vaccination programme. Those could easily be shared, and we will offer them to anybody who wants them. Some of that will be done through personal relationships that we have with countries; some of it will be through our relationship with the WHO via the UK.

Willie Coffey: I do not know whether you heard Dr Buist's comments in the previous session. He basically said that, in his view, the roll-out strategy in Scotland is the correct one and that, had we chosen the GP route, the practices alone could not have done it.

I invite you to look to the future. Sadly, you will not be in Parliament to help us do this, but if we discover that we have to vaccinate annually, do you think that the roll-out model that we have in place is the one that we will continue to use—that is, to use vaccination centres—or could vaccination slowly and progressively be carried out by GP practices?

Jeane Freeman: That is another good question. I know that that is Dr Buist's view, and am glad that he has it. However, it is important that our GP community is with us in all this, and we have listened to what it has to say. Part of its rationale, and therefore mine, is that the GP community must be able to respond to the health needs of local citizens. If we were to ask GPs to do the whole vaccination programme, it would become impossible for them to respond to those health needs, because vaccinating people would be all that they could do. We cannot have that. We need non-Covid health issues to be responded to and dealt with. I am sure that the committee has looked at the implications for non-Covid health issues of our necessary response to the pandemic and the virus—the Parliament certainly has, and I am constantly thinking about that.

12:30

We now have a mixed approach, which includes GP involvement through GP and primary care practices, using a wider cohort of staff than just GPs, including practice nurses and district nurses. Those settings are right for the older population and for those who are housebound or vulnerable. We do not want them to have to travel far to get their vaccine, so they are able to get it very locally.

Also in the mix are larger local centres, which people have to travel to, and mass centres, which people might have to travel to from a distance. As the size of the centre is scaled up, more and more of the population can go through it. The balance has to be right. There is always a trade-off between making sure that a setting is as close to people as possible when that makes sense for their age and stage of life—their frailty and so on—and making it as big as we can, in a sensible way, for those who can get to those bigger centres, because we will get through the population quicker.

I think that, overall, the bones of that approach are right, although, undoubtedly, the approach is not perfect. There will be loads of fixing it as we go and more improvements to be made for the next iteration.

There are another two key points. The first relates to national infrastructure, which includes the national ServiceNow system and the vaccine management tool. There is huge value in having that data collection in as close to real time as can be managed.

Secondly, serious thought is being given to having a larger cohort of vaccinators across Scotland. You will know from your own experience that we have a cohort of vaccinators in our health boards who do the flu vaccine every year. We might supplement that group; it has been central to this programme. We are certainly thinking about whether we need to make that core vaccinator cohort larger, so that we can cope with a bigger-scale programme year in, year out.

Willie Coffey: That is really helpful—thank you very much for that response.

The Convener: Our final questions, on vaccine passports, come from David Stewart.

David Stewart: I want to ask about a bigger-picture issue: vaccine passports. As you know, there has been a lot of debate about it; I think that I asked Jason Leitch a question about it some weeks before. The idea that I have comes from the Tony Blair Institute for Global Change, which has looked very carefully at the vaccine passport. Such passports should be internationally recognised, digital—[*Inaudible*.]. In a sense, there is nothing new about that. There is a yellow fever immunity passport, which has been well kent in the scientific community for some time.

Where are we with that in policy terms, cabinet secretary? You will be well aware that the EU is already up and running—the train has left the station. It has looked at the interoperability of vaccine certificates already, because of pressure from the Greek Government. Airlines such as Qantas have already looked at it. I understand from this morning's *Press and Journal* that the Secretary of State for Transport at Westminster has already started discussions with the American and Singapore Governments about it. Have you discussed the policy with other nations? Have you raised the issue, or has it been raised, in the Scottish Cabinet?

Jeane Freeman: We have had some discussions about that. We are not opposed to vaccine passports or to the interoperability of such certificates, but we must be clear about their purpose. That clarity will be informed by our growing understanding of the impact of the vaccines. We know from the clinical trials that the two vaccines that we are using are very effective in preventing serious illness and death among those who are at the greatest risk of serious illness or death, but we do not know whether the vaccines have any impact on transmissibility, which is, of course, key to controlling the virus.

Public Health Scotland, working with partners across the UK and beyond, is looking at the impact of being vaccinated. Do people who have been vaccinated acquire the virus? Do they become seriously ill? What happens to them? It is a big, real-time trial that will add to the data that we already have. We are well aware of the international interest in that.

I think that there will come a time when vaccine passports will have real value for individuals. I am not saying that that is away in the future, so let us not talk about it now. I am keen to ensure that the wider public understand the limitations of vaccination, based on what we know. I have heard people say, "Now that my granny's been vaccinated, I can go and hug her." I would prefer that they did not, even after they, too, have been vaccinated, until we are sure about what is happening with transmissibility and case levels. There is no one thing that will take us to a safer place; a number of things will take us to that safer place.

David Stewart: I do not necessarily disagree with the cabinet secretary. I want Scotland to be a leader on this. We are in the station, but the train is leaving. The EU and individual companies—I have mentioned Qantas—are jumping ahead with the issue. I did not realise until I heard the earlier evidence that the BMA conference had voted unanimously in favour of passports.

Jeane Freeman: It did.

David Stewart: I cannot see how we can rebuild our economy and our domestic and international tourism sectors without having some form of internationally recognised vaccine passport. That might just reflect the tests that have been carried out. It would be appropriate for a body such as the World Health Organization to look at the science and to say what must happen. Countries will not accept tourists unless there is some sort of passport.

I refer to what Dr Buist said earlier. I do not want a non-digital system, with people plaguing their GPs for vaccination certificates. It must be done digitally. We cannot build up the world's economy and tourism without that.

I want to press you on that, cabinet secretary. The G7 meeting that is coming up will be hosted by the UK. Is that not an opportunity to take a leadership role and not follow?

Jeane Freeman: There is nothing in what Mr Stewart has said that I disagree with, but I struggle a wee bit to see what the leadership role would be until some of the known unknowns are clarified and we are clear about what the World Health Organization would consider to be an effective vaccine passport or certificate—however that is defined—that would give individuals and the countries that they go to a degree of assurance about virus transmission and the safety and efficacy of vaccines.

You should not take what I say about what we still need to know as being an indication that I want us to go slowly or to do things at the last minute. There are advantages that Scotland has. One of our great advantages is our community health index number system and the way in which our data is stored. That is proving invaluable to many companies and academic institutions for wider health research—for example, on the whole genomics question. We have advantages but, in order to point those advantages in the right direction, we need a bit more information about the purpose of a vaccine passport, what information it needs to contain and how we can make it happen.

I do not disagree with a word that Mr Stewart has said.

David Stewart: I have a final question for the cabinet secretary before I move on to Caroline Lamb and perhaps Jason Leitch.

On the leadership front, could you talk to the Secretary of State for Transport or Michael Matheson about what discussions they have had with America and Singapore? Could you have a discussion with the EU about its policy of interoperability? Could you have a discussion with the WHO about what is going to happen on the international stage to get such a passport recognised? Of course there are issues—Jason Leitch raised that with me a few weeks ago. I am not being frivolous here. I know that there is the saying that, when you are in the swamp, you do not worry about the ozone layer, but I think that it is important that we look at the international movement. We must think beyond Covid and get the world economy and our tourism sector back on their feet.

I have given you three suggestions, cabinet secretary.

Jeane Freeman: Those are very welcome suggestions. I completely agree with you. Although we are very focused on where we are right now and what we need to do, please do not take that as indicating that we—not just me, but the Cabinet as a whole—are not focused on how Scotland builds back. Mr McKee published our approach to international trade not very long ago. International trade, imports and exports, and relationships with other countries, including on tourism and other matters, are extremely important to building Scotland back. That work is under way.

If it would help, I will check what conversations Mr Matheson has already had. I know that he speaks to his UK opposite number on a regular basis. I do not know whether Jason Leitch can add anything as regards where we think that the WHO is. In addition, of course, Mr Russell is very focused on Europe and other international matters, given where we are at the moment. I will double-check what conversations they have had, as well as taking on board and taking back your suggestions.

David Stewart: I know that we are tight for time, but I would like to put a brief question to Caroline Lamb. I congratulate you on your appointment as director general for health and social care. Could you tell the committee how many Scottish Government staff are working partly or fully on the issue of international vaccine passports?

Caroline Lamb: Thank you very much for your congratulations. I do not have that information to hand, but we can certainly access that and provide it to you.

David Stewart: Thank you. Does Jason Leitch have any final points on the vaccine passport issue?

Professor Leitch: I think that I can reassure you, Mr Stewart. I sense and feel your urgency. I can reassure you that that conversation is being undertaken with urgency, but it is taking place in the context of an evidence base that is moving. That is the cabinet secretary's key point. We simply do not know what an international vaccine passport means, but when we do, we will be ready. Consideration is being given to what that could mean at a UK level—the UK senior clinicians are considering that—at an organisational level and at a WHO level.

The yellow fever vaccine certificate is a WHO-led global response to yellow fever. Therefore, there is a precedent. However, we know what yellow fever vaccination does and we know how to protect countries from yellow fever, but we do not yet know what Covid vaccination will mean or do.

I can reassure you that that conversation is taking place at each of the levels at which you would expect it to take place. That conversation is not just about international travel; it is about trade and the ability to visit care homes and do any of the things that we want to get back to doing. A single sheet of paper with a green or a red mark on it will not resolve that, but it is part of the package that might, in the end, resolve some of it.

David Stewart: Thank you. I appreciate that.

Caroline Lamb: May I come back in?

The Convener: Yes, please do.

12:45

Caroline Lamb: I know that, in the earlier session, Andrew Buist said that he was keen that the data should be available digitally. As the cabinet secretary described, we have two sources of data on people who have been vaccinated: the vaccine management tool and the GP IT infrastructure. I reassure the committee that, through the infrastructure that we have built, all that data is brought together in our national clinical data store, and we are therefore well placed to be able to offer citizens a way in which they can access that information digitally rather than having to approach their GP for any form of certification.

The Convener: Maurice Corry has one quick question, after which we will have to move on.

Maurice Corry: What is the position for essential business travellers when they return to Scotland in relation to quarantine requirements and possible costs if they have to go into a hotel for 10 days or whatever it is? Perhaps the cabinet secretary could answer that question.

Jeane Freeman: Of course. Michael Matheson is working through the detail of the exemption list. We want to tighten that a bit, but we also need to take account of the individuals to whom Mr Corry referred as well as those who are currently required to quarantine before they go offshore, for example, and think about what those arrangements might be.

This morning, I heard a representative of the National Union of Students raise the issue of overseas students. All that is being worked through just now, as it has been all week, by my colleagues in higher education and Mr Matheson. As soon as they have resolved those issues, we will ensure that everyone knows and understands the situation.

The Convener: There was another question from Willie Coffey, to be directed to Jason Leitch, but we do not have time for it today. It was about research into why healthy younger people are becoming very ill. Perhaps Professor Leitch could take that point away and we can return to it next week. I am sorry that we do not have time to deal with it today.

Professor Leitch: Of course, convener—I anticipate being back next week.

The Convener: Thank you.

That concludes our evidence session. I thank our witnesses for their evidence, particularly the cabinet secretary, Jeane Freeman, the chief executive of NHS Scotland, and the national clinical director. We have had helpful and comprehensive answers, especially on the vaccination programme.

Subordinate Legislation

Health Protection (Coronavirus) (Restrictions and Requirements) (Miscellaneous Amendment) (Scotland) Regulations 2021 (SSI 2021/49)

Health Protection (Coronavirus) (Restrictions and Requirements) (Local Levels) (Scotland) Amendment (No 15) Regulations 2021 (SSI 2021/54)

12:47

The Convener: Agenda item 3 is consideration of the motions on the subordinate legislation on which we have taken evidence under agenda item 2. Cabinet secretary, do you have any remarks on the Scottish statutory instruments before we come to the motions?

Jeane Freeman: [*Inaudible*.]—thoroughly, and I am happy to answer any questions if there are any, but I have nothing more to say.

Motions moved,

That the COVID-19 Committee recommends that the Health Protection (Coronavirus) (Restrictions and Requirements) (Miscellaneous Amendment) (Scotland) Regulations 2021 (SSI 2021/49) be approved.

That the COVID-19 Committee recommends that the Health Protection (Coronavirus) (Restrictions and Requirements) (Local Levels) (Scotland) Amendment (No. 15) Regulations 2021 (SSI 2021/54) be approved.—[*Jeane Freeman.*]

Motions agreed to.

The Convener: The committee will publish in due course a report to Parliament setting out our decision on the statutory instruments that have been considered in this meeting.

That concludes our consideration of agenda item 3 and our time with the cabinet secretary. I reiterate our thanks to all our witnesses for their attendance.

That also concludes our business for this meeting. The next committee meeting will take place on Thursday 18 February. The clerks will update members in due course on the arrangements for it.

Meeting closed at 12:49.

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