OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 7 October 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Thursday 7 October 2021

CONTENTS

COVID-19 RECOVERY COMMITTEE
7th Meeting 2021, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jonathan Cameron (Scottish Government)
Derek Grieve (Scottish Government)
Professor Nicola Steedman (Scottish Government)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 7 October 2021

[The Convener opened the meeting in private at 09:00]

10:00

Meeting continued in public.

Decision on Taking Business in Private

The Convener (Siobhian Brown): Good morning and welcome to the seventh meeting in 2021 of the COVID-19 Recovery Committee. The second agenda item is a decision on taking in private item 4, which is consideration of the evidence that we will hear. Are members agreed?

Members *indicated agreement.*

Vaccination Programme and Pandemic Preparedness

10:00

The Convener: Our next item of business is the taking of evidence on the vaccination programme and on pandemic preparedness. I welcome Humza Yousaf, Cabinet Secretary for Health and Social Care, who is supported remotely by his officials from the Scottish Government: Derek Grieve, head of the operational vaccines division; Professor Nicola Steedman, deputy chief medical officer; Karen Duffy, deputy director, Covid vaccination delivery; and Jonathan Cameron, interim director of the digital health and care directorate. Thank you for your attendance.

Cabinet Secretary, would you like to make any remarks before we move to questions?

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Thank you, convener, and good morning to all. It is a pleasure to be in front of the committee. I have just a few brief opening remarks.

I emphasise that Scotland's Covid-19 vaccination programme, along with those of the other three nations of the United Kingdom, has been one of the fastest in the world—a roaring success—and remains our best route out of the pandemic. As the programme now pivots to deliver booster vaccinations ahead of winter, I am pleased to report that, of people aged 18 and over, 92 per cent have had a first dose of a Covid vaccine and 86 per cent have had a second dose. In addition, a further 72 per cent of 16 and 17-year-olds, and 28 per cent of 12 to 15-year-olds have been given a single dose of vaccine.

Those remarkable achievements have been possible only through the colossal and Herculean effort of our national health service, delivery partners, volunteers, the Army and the many who have been involved in what is, as I have said, a roaring success. I thank them for their immense contribution to the success of the programme in meeting and surpassing its targets. Thanks must also be given to the general public for coming forward, taking the time to read and understand the information about the vaccine and making themselves available to get vaccinated.

One of the most demanding aspects of the programme has undoubtedly been the challenge of reacting and adapting to advice from clinical experts. I thank them as well, because perhaps they do not often get enough recognition for the difficult decisions that they have to make. I particularly wish to commend the resilience and responsiveness that has been demonstrated in

moving rapidly to implement new clinical advice as it has emerged throughout the programme—for example, in extending our offer to 12 to 15-year-olds, following advice from the Joint Committee on Vaccination and Immunisation and the four UK chief medical officers.

Our NHS has sustained a track record of innovation over the course of the programme in meeting those challenges, including, for example, the launch of the online appointment booking process and the vaccine management tool to record vaccinations. It has exhibited an ability to continually learn from the outcomes of the programme. That has been reflected, for example, in our changing approaches to addressing low uptake of the vaccine among minority groups.

We maintain the position that a mandatory domestic certification scheme remains a necessary and proportionate measure that will encourage vaccine uptake and allow our higher-risk settings to continue to operate, as an alternative to closure or more restrictive measures, should cases spike again.

The NHS Scotland Covid status app, which features a digital record of a user's vaccination status, including a QR code for each vaccination that a person has received, went live on 1 October. As set out by the First Minister last week, enforcement provisions do not come into effect until 18 October. Not only are we aware of the difficulties that were initially faced by some users in setting up the app; we regret and apologise for them. We have resolved those issues, and the app is now working well. Of course, it is also possible for members of the public to request a paper copy of their vaccination record or to download a PDF version from the NHS Inform website.

I am grateful to all organisations and individuals who are working to implement the scheme. As public confidence and trust underpin the success of the vaccination programme, the Government remains very much committed to upholding transparency and openness around our plan. Members will recall the statement that I made last week on our autumn and winter vaccination programme, and Public Health Scotland continues to publish daily vaccination data on its website. In 10 months, we have delivered more than 8 million Covid vaccinations. With the addition of Covid boosters, flu vaccines and jabs for new groups, we will now need to deliver roughly the same number of vaccinations—or just slightly under, at about 7.5 million—over the autumn and winter period.

That is a huge job for our NHS, so I end where I started by thanking the service for its incredible efforts. I look forward to the committee's questions.

The Convener: Thank you, cabinet secretary. I will begin with a question on vaccine roll-out. Audit Scotland has commended the progress that has been made, stating:

> "The Covid-19 vaccination programme has made excellent progress in vaccinating a large proportion of the adult population ... Vaccines have been delivered in a variety of ways to make it easier for more people to access them, and the level of vaccine wastage has been low."

What lessons can we learn from the successes of the vaccination programme, both for future programmes and for the wider delivery of public services?

Humza Yousaf: The programme has been a success, and I am really pleased with the Audit Scotland report. Indeed, I met the Auditor General just before the report was due to be released. I know of Audit Scotland reports that are quite challenging for the Government—and rightly so, given that it works independently of us. Its reports get a lot of attention; I was hoping that this report, too, would get the same attention, but it has not. Nevertheless, it is quite remarkable just how positive that report is.

There is a really important point at the nub of your question. We are doing a lot of work with our partners to try to learn lessons from this success and to find out not just how we can implement the same measures in other vaccination programmes but whether we can use them to have better joint working across a range of our programmes. We have undertaken an exercise that includes interviews with health boards, vaccination leads and many others to try to embed any lessons learned into any future vaccine delivery programme.

Some of that learning has evolved with regard to, for example, how we reach groups in which uptake has not been as high as we want it to be. I should also highlight the good conversations that are taking place across the four nations. I usually meet the other health ministers every week, and our officials, too, meet extremely regularly to see where we can share good practice. To my annoyance, sometimes, Wales has often been slightly ahead of the curve, and we have found ourselves having to catch up with regard to vaccinations. Indeed, I speak often to the Welsh health minister to find out whether the Welsh are doing anything that we are not.

We are absolutely learning these lessons. The key issue, I suggest, is how we mobilise the wider public sector and, indeed, the third sector, which has also been involved in the vaccine roll-out, at pace and at scale. Indeed, I think that this is probably a good example of what Campbell Christie and the Christie commission talked about.

The Convener: Before the meeting started in public, we had a fascinating briefing with our advisers. Professor Donnelly from the University of St Andrews said that, although it might seem that nothing worse than the Covid pandemic could hit us, one thing that might be worse would be a digital technology blackout. Is the Scottish Government doing any work on ensuring digital preparedness and security?

Humza Yousaf: Yes. Indeed, one of the key meetings that I had early on as health secretary was with cybersecurity experts. Frankly, there is still work to be done in that respect. We have seen some of these issues aired publicly, with the previous breaches of cybersecurity in some health boards, so we must ensure that our systems are robust.

Generally when it comes to our digital tech and infrastructure in the NHS, we have a way to go. That goes not just for the issues with the Covid app, which I would be happy to talk about in more detail; in general, the ambitions that we have for digital infrastructure are just that: very ambitious. We need to move ahead on them at scale and at pace. However, we are doing a lot of work with health boards and others to try to bolster our cybersecurity, because it is incredibly important.

The Convener: My last question is on the spread of vaccine misinformation, especially on social media, which ranges from claims that the Red Cross has banned blood donations from vaccinated people to the claim that deaths from vaccines have overtaken Covid deaths. What is the Scottish Government doing to counter such misinformation?

Humza Yousaf: That is a good question. A lot is going on in the social media space. We try to get clinicians to lead a lot of that work, but we also use social media influencers as well as we possibly can, since they—as the name suggests—carry significant influence among people who are on social media, where a lot of that disinformation is spread. Sometimes that works well, but there are obvious examples of where it has not worked as well as we had anticipated.

I would also caution against thinking that disinformation is just in the social media space, because it is not. There have been examples, even in Scotland, of people rocking up to school gates and presenting a letter that looks like an NHS information leaflet but which contains a host of disinformation. We have reacted very quickly to that and have been to speak to the school and send communications to the parents of the children who were involved.

Countering disinformation is going to take a multi-pronged approach. Our social media and digital activity is going to have to involve taking on quite robustly some of the disinformation that exists. It is a multi-pronged approach to, frankly, a global issue that we are all trying to deal with.

I am pleased to see that some social media sites, such as Instagram, I believe, say quite clearly whether information that is posted about Covid-19 is certified or not—forgive me if I am wrong about that being Instagram; I am on quite a lot of platforms. We should encourage social media companies to do a lot more to tackle disinformation where they can.

The Convener: Thank you.

Murdo Fraser (Mid Scotland and Fife) (Con): My question follows on neatly from the convener's last question, as it is about vaccine hesitancy. The committee has taken evidence from experts around that issue. There is a difference between anti-vaxxers and the vaccine hesitant, as you will know. Anti-vaxxers are people who are ideologically opposed to vaccination and nothing will persuade them otherwise—they just do not trust the authorities.

The vaccine hesitant are a different group. They are people who perhaps have hesitation about vaccines but are not intrinsically opposed to them. I am interested in what more is being done to try to encourage the vaccine hesitant to take up vaccination. From the data that we have been provided with, we see that some of the vaccine hesitant are young people, but the most stark differences are by ethnicity. For example, according to the latest figures, just under 80 per cent of the white population has had two doses of the vaccine, but that figure is 52 per cent among people of Black origin and 64 per cent among people of Asian origin. That is quite a substantial gap.

What is being done by the Scottish Government to understand the reason for vaccine hesitancy among those ethnic groups? Can we learn anything from other countries or other parts of the UK? Are their figures different, and are they better than ours? What more is being done to tackle hesitancy in those groups?

Humza Yousaf: That is an exceptionally important question, and I agree with its premise that there is a difference between vaccine hesitancy and being anti-vax. It is important that we do not stigmatise people who have legitimate questions about the vaccine, and that is probably particularly important when it comes to the 12 to 15-year-olds.

I am a stepfather of a 12-year-old. Given the nature of my role, I know more about the vaccine, but when it comes to your children, you are naturally going to have more questions and potentially more hesitancy. Our informed consent process is important, because it allows a parent or

a carer to go into a vaccine clinic and speak to a vaccinator and ask very legitimate questions.

The anecdotal evidence that I have received when I have spoken to health boards is that parents and children themselves are asking a lot of questions. I have been buoyed by the fact that vaccinators tend to engage with the young people and say that they are happy to answer any questions that they may have.

10:15

On the substance of the point that you raise, a lot of work has been done to try to understand vaccine hesitancy among ethnic minority groups—I will come to young people, although there is obviously intersectionality between those groups.

We have been helped a lot by the good work that BEMIS has done. It has created and leads a group—forgive me, I cannot remember its name off the top of my head—that includes a variety of people who represent a number of ethnic minority populations. I have spoken to that group to try to understand where some of the hesitancy exists.

A number of representatives from the black and African communities, as well as the Polish and Gypsy Traveller communities, gave me some really helpful feedback. We have used that feedback to try to make our vaccination programme more accessible to those groups. For example, we have taken mobile units to the Sikh gurdwara and gone to churches that the black and African communities go to in large numbers. We have also translated material into a number of languages.

We have also tried to use community influencers. For example, clinicians from the South Asian community and the Muslim community came together to produce a video using not only clinicians but—this was quite smart—faith leaders, who we know can have a fair degree of influence among a number of groups.

We have tried to speak directly to young people to understand some of the reasons why they are vaccine hesitant. I will give one example of how we used that useful intelligence.

We noted early on that, once we went into the 18 to 29-year-old age bracket, a fair degree of the feedback that we got was about people's concerns about fertility. People in that age group who wanted to try for a baby were worried about the impact of the vaccine. Therefore, we really boosted the communications around the vaccine being recommended for pregnant people and it having no effect at all on fertility. We tried to target that communication on social media and online.

Murdo Fraser: Thanks for that comprehensive answer. The one issue on which you did not touch is whether there is any difference in those figures in any other parts of the UK. I am interested in whether you have any data on that. Are you aware of any difference?

Humza Yousaf: Forgive me. You are right that I did not touch on that. I do not have that information to hand and do not know whether any of my officials do. I would be surprised if we differed greatly but Karen Duffy or Derek Grieve might have more information on that. If not, we can write to the convener.

Derek Grieve (Scottish Government): I do not have that information to hand. We can, of course, provide it. I reassure the committee that we have regular discussions with our colleagues across the four nations and share learning. That has included how we have all tackled underrepresented groups.

Murdo Fraser: If you get some more data, that would be interesting.

We have had many conversations about vaccination passports. Last week, the committee took evidence from Professor Stephen Reicher and two of his colleagues. They all raised concerns about a backfire effect from making vaccination passports compulsory in certain circumstances and said that it could have the unintended consequence of making it less likely that some vaccine hesitant people who start from being distrustful of authority would take up the vaccine.

Those witnesses all made the point that Scotland is the only country in Europe that now requires vaccination passports as the price of entry to certain events without giving the alternative of providing a negative Covid test. Their view was that allowing that alternative would deal with the backfire effect. Has the Scottish Government given serious thought to that, given that those experts are saying that it is a real worry?

Humza Yousaf: We engage with those experts regularly; indeed, someone like Professor Stephen Reicher carries considerable weight when he speaks. We have, of course, considered what you have highlighted.

The First Minister has said that we are not ruling out having to produce a negative test in future, but we are not introducing that measure with the implementation of this scheme, because a requirement for an unsupervised lateral flow test can be abused and people can gain entry to venues by falsifying the result. We are trying to make the scheme as stringent as possible on implementation.

I am not taking away from what Stephen Reicher or, indeed, Murdo Fraser has said with regard to those who might be vaccine resistant

becoming entrenched in their views, and we are keeping a close eye on the matter. We will evaluate the impact of the vaccination certification scheme through a variety of data sources, including information that shows whether we are seeing an uptick in the vaccination rate. When we announced our intention to have a vaccination certification scheme, we saw such a rise, particularly among the younger age groups. We will keep these things under review and, as you would imagine, look at other metrics such as case numbers and hospital bed and intensive care unit occupancy as well as wider societal and economic impacts. All such matters will be regularly considered; indeed, we will review the scheme every three weeks, as Murdo Fraser knows, and we will continue to engage with stakeholders.

That said, we are very aware and conscious of the points that Murdo Fraser and Professor Reicher have made, and we will keep a close eye on them.

Murdo Fraser: Thank you.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): We are now getting a good response from the younger generation, but do you have any figures that show that the introduction of vaccination passports has increased vaccine uptake? Moreover, although I am delighted to hear that you are working with ethnic communities to address vaccine hesitancy, is any monitoring and measuring being done to show whether that messaging, as it is being developed, is increasing uptake, why there was hesitancy in the first place and whether we are overcoming it?

On the issue of misinformation, people are entitled to their own opinion, but not to their own facts. Do we need legislation to stop people putting out information that is factually incorrect and dangerous to public health?

Humza Yousaf: You have asked a number of very good questions.

First, the Republic of Ireland was ahead of us in introducing a vaccination certification scheme. Indeed, I noticed an article on the BBC news website in which immunology expert Professor Kingston Mills of Trinity College Dublin said that, if it had not been for the certification scheme, uptake of the vaccine

"would have been much lower"

and that the scheme had been a "big incentive" for people to get jabbed. We will keep Scotland's figures under close review, but I note that, in the two weeks after we made the announcement on 1 September, there was a 10 per cent increase in vaccine uptake in the 18 to 29-year-old age group. As we know, the younger the age group, the lower the uptake tends to be, so that was a positive sign.

Vaccine uptake is lower among not just younger age groups and minority ethnic groups but people from more deprived areas, and we will monitor those groups as the vaccination certification scheme gets embedded in the hope that uptake will increase. However, as I am sure some of your advisers will have highlighted, the point is that anything that we can do to increase uptake will be important. We do not want people in the groups that have a lower uptake of the vaccine not to go to live events, late venues, the football and so on. We are working hard to ensure that the information on certification is, for example, translated into other languages.

On your last question, we are not planning for legislation. We will do everything that we can to counter misinformation without going down a legislative route. That is for a number of reasons, one of which is that legislation takes time and we want to counter misinformation now. However, we will keep the matter under review.

Jim Fairlie: To go back to the issue of groups that have a natural tendency to not want to be vaccinated, we have spoken in the committee about the fact that a good chunk of those groups will not necessarily go to the football or whatever. We have regularly discussed the messaging that is being targeted at those groups. Will that messaging increase uptake of the vaccine, so that we know that the messaging is getting through?

Humza Yousaf: Causation can be difficult to prove definitively. I know that, for example, when we took a targeted approach to 18 to 29-year-olds—young people—the feedback on that messaging was positive. I will see whether we can get more certain information on causation, and we can write to the convener, who can distribute that information to committee members. Causation can be difficult to prove.

I do not think that any group has a natural tendency to not get vaccinated. Even among groups in which vaccine uptake is lower, uptake is still high, which is positive—it is just lower than that for other groups. We must ensure that we continue to make the vaccine as accessible as possible to individuals from groups with lower uptake rates. As restrictions ease and as case numbers, thankfully, begin to reduce, we have a challenge in telling people, "Look, you still have to get vaccinated. We are thankful that life is getting back to some sort of normality, but it is an unpredictable virus, and there could be future spikes, so you do not want to be unprotected." The figures for people who are hospitalised and become seriously ill among those who are vaccinated versus those who are unvaccinated tell their own story.

The Convener: Professor Nicola Steedman would like to come in.

Professor Nicola Steedman (Scottish Government): I will embellish the cabinet secretary's answer a bit. We monitor carefully the impact that the changes that we make to the vaccination programme have on the groups for which we know that, classically and historically, uptake is lower, including those in higher levels of deprivation and some ethnic minority groups. You will know about some of the actions that we have taken to counter that low uptake, such as taking the vaccine to places where we know people might be more hesitant. That is clearly monitored—we can see whether taking the vaccine to those groups results in increased uptake. Our national inclusive steering group keeps a close eye on that.

We know that it works to have local champions—people with whom those groups identify—giving people information about vaccination. We have employed that approach across groups in which vaccine uptake is lower than we want it to be. In many behavioural studies, that has been shown to be one of the most effective things to do. We also share learning across health boards in Scotland. The way that we work across Scotland is so tight and inclusive that, if one health board has a measure that has worked well with a particular group, that learning will be shared through our vaccine programme board across the whole of Scotland in order to increase uptake.

As the cabinet secretary mentioned, we are in the midst of a lessons learned investigation and report, along with Public Health Scotland, about our vaccination programme, including the inclusiveness element. We are looking at whether particular measures have been more successful than others at increasing uptake in some groups. Along with the cabinet secretary, we can assure you that, from a clinical point of view, that is done first and foremost in the vaccination programme, and there is an extensive programme of work to increase inclusiveness, including monitoring what does and does not work.

The Convener: Thank you, Professor Steedman.

10:30

Alex Rowley (Mid Scotland and Fife) (Lab): I will pick up on a couple of things. In the past few weeks, I have met staff and trade union representatives from the front line in our NHS. They would argue that, although the announcement that was made yesterday was welcome, it should have been made earlier and—more important—it does not go far enough when it comes to the resources that are needed. I have had feedback that the pressure is immense. At times, the hospitals are, in the words of the people whom I have met, not safe—the nurse to patient ratio is way beyond what is acceptable. Do you have a grasp of the extent of the problems in our hospitals? Do you accept what those nurses and trade unions are saying about the numbers of nurses being so low in comparison with the numbers of patients that there are serious safety issues in hospitals?

Humza Yousaf: I am happy to answer questions about my statement last week. First, when any of our trade unions speak up and speak out, they will be listened to by the Government. I spoke to the trade unions last week about my statement, before I made it, and about additional funding for the Scottish Ambulance Service. I speak to trade unions regularly. You talked about nursing. I spoke to the Royal College of Nursing on, I think, Friday past. We speak and engage regularly with trade unions and take what they say very seriously.

The answer to your question is yes—the Government and I have a grasp of just how serious the situation is across our NHS and social care. It is important to talk not just about the pressure in hospitals; there is also significant pressure across social care. That is why the announcement that I made included the biggest winter pressure funding package ever announced in the history of devolution—which is as it should be, because we will face more pressure this winter than we have in any other winter, not just under devolution but, probably, in the NHS's 73-year existence. The funding will, I hope, go a long way in making an impact not just on the acute side but in primary care and social care in the community.

On your specific questions, I hope that any concerns about patient safety are flagged up to the local health board initially, but to the Government as well. We have the highest ever level of staffing in the NHS under any Government, and we will continue to recruit. My statement set out significant ambitions for the recruitment of not only nurses but staff in bands 2 to 4.

However, I have to be up front with the member and with the public. The measures will help to mitigate some of the challenges, but we are still in for an incredibly difficult winter. Clinicians tell me that they are concerned not just about Covid pressures—albeit that we hope to make a significant dent in those as we control transmission—but about the flu and other respiratory viruses, because we suspect that our immunity is quite low. Flu had not been circulating as much due to the lockdown and the restrictive measures that we were under, so the concern is that people's immunity is low.

I promise Alex Rowley, the trade unions and—most important—the public that every penny that

we get through additional consequentials on health and social care will be spent on health and social care. We should get more clarity on the level of those consequentials after the UK Government's spending review, which I think is on 27 October. If additional funds come to health and social care, I promise that we will get those out of the door as soon as possible.

Alex Rowley: I have raised social care issues with the First Minister and the Deputy First Minister over the past few weeks. We might need to have a much more focused task force, because I am not sure that the capacity to deliver exists within the current management set-ups of the health and social care partnerships. However, that is for another day.

Do you accept that, this winter, more people will die of cancer and other health harms that could have been prevented and that that will be a knock-on effect of Covid? How do you balance the focus on Covid with a focus on other harms in the community?

I note the statement that you made with, I think, Andrew Buist about general practitioners. I know of constituents who were unable to get a GP appointment and, through another route, ended up severely ill at hospital. There are real harms out there. I acknowledge that, before Covid, a massive amount of good work was going on in health centres to triage people—I am not suggesting that we suddenly go back to everyone getting a face-to-face appointment—but there has to be a guarantee for people who feel so ill that they need such an appointment. How will our NHS cope with that? After all, the threat of death now comes not so much from Covid but from the knock-on effect on all the other health ills that have not been dealt with because of the focus on Covid.

Humza Yousaf: I thank Mr Rowley for that series of good and comprehensive questions. He should forgive me if I miss anything—I was trying to jot things down as he was speaking.

Mr Rowley is right to say that Covid has direct and indirect health impacts. I am afraid that the direct impacts are still being felt by families up and down the country, including in his region and in my constituency. I cannot pre-empt the figures that will come out later today, but it will come as no surprise to learn that a number of families will have been devastated by the loss of a family member to Covid. Those numbers are still too high, and again I, like everyone, will want to give the people involved our condolences. We can probably all tell stories of people either in our own families, unfortunately, or whom we know who have lost somebody and been bereaved by Covid. It is important to point out that those impacts are still with us.

Mr Rowley is also right about the indirect consequences of Covid. There is no getting away from the fact that Governments across the world, including those in the rest of the UK, had to make exceptionally difficult decisions. The toughest decision that we, collectively, as a Government had to make was to pause some cancer screenings at the beginning of the pandemic. We resumed them as soon as we could in, if my memory serves me correctly, August 2020. Those were tough, tough decisions. Even now, health boards, including those in Mr Rowley's region, are having to make really difficult decisions about pausing elective surgery. A member of my family has been waiting for surgery; he understands the reasons why it has not taken place, and his pain can be managed at home, but it is still difficult for us to see him having to wait. I suspect that Mr Rowley will be able to recount similar stories from his constituents or even from his own family.

We are very aware of that situation. In fact, the pressures on our hospitals that Mr Rowley referenced in his first question are more to do with indirect effects of Covid. There are just under 1,000 patients in hospital with Covid, which means that they are taking up more than 900 hospital beds. I hope that that figure will come down as Covid transmission is controlled, but as any nurse, any doctor or anyone else involved in an acute or primary care setting will tell you, the significant pressure comes from the pent-up demand from people who have been unable to see a GP or go to hospital for 18 months. Their pain is worse—they are now presenting with a higher level of acuity—and, as a result, they have to stay in hospital and take up bed space for longer.

We are very familiar with the issues that Mr Rowley has raised. That is why we have taken the decisions that I set out in my announcement yesterday about winter. With the onset of the flu season, we have to free up and maximise capacity as best we can. A couple of weeks ago, Mr Rowley made a very good point either at First Minister's question time or following one of the First Minister's statements about how investing in social care—where, I should add, a significant amount of the funding that I announced is going—will, I hope, allow us to free up capacity by ensuring that those who are clinically safe to discharge but who are currently taking up about 1,500 hospital beds get safely discharged into the community. Indeed, that would be better for the system as a whole.

As I said, every Government across the country had to make tough decisions. For example, I speak to Eluned Morgan fairly regularly, and I know that the Welsh Government had to make such decisions, as did the UK and Northern Irish Governments.

As for face-to-face GP appointments, I note that Mr Rowley referenced my joint communication with the British Medical Association. First of all, we want a hybrid model to continue, because it works for a lot of people. In August, when I had an eczema flare-up, I was able to phone the doctor in between meetings and get the prescription for the ointment that I needed sent to the pharmacist, to be picked up later in the afternoon. That meant that I did not have to take any time out for a face-to-face appointment. For some people, therefore, the hybrid model works well, because they want a telephone appointment or video consultation.

However, what I say very clearly and in black and white in the joint communication with Dr Buist is that, given the changes in guidance that were recently published by Public Health Scotland, I expect an increase in the number of face-to-face appointments. That is the desire of the Government, but we also have to take into account a clinician's own decision, because neither I nor Mr Rowley should determine when a patient should be seen face to face. That said, I agree with his premise that an individual who requires a face-to-face appointment should get one.

Alex Rowley: My experience, like yours, has not been bad; I made a phone call, and the doctor at the other end said, "I want to see you." However, I have examples of family members and others being told, "Just take some antibiotics", and then ending up at hospital. The advice was completely wrong.

It is a question of clinical judgment. A GP or someone else in the health service might say that they are making a clinical judgment that they cannot see anyone, but given the stories of people being refused an appointment, being told that they can just get antibiotics and then ending up at hospital hours later with something seriously wrong with them—I am sure that there are many such stories; I have certainly seen that happen at first hand—is there not a duty on you to ensure that that does not happen? This is all about getting the balance right, and I am not sure that simply saying that we are not the clinical experts in such matters does that. Surely people should be able to get a face-to-face appointment of some sort if they are so ill that they feel that they need one.

Humza Yousaf: I agree, and my hope—indeed, my expectation—is that the vast majority of GPs will see someone who might become seriously ill face to face.

I will make two points. First, I want a significant improvement in the data that we get from GPs. Indeed, when I came into post, it became clear to me that the data from them—I fully accept that they are independent contractors and that we have to respect the model—could be better. In my conversations with the BMA and the Royal College of General Practitioners, they agreed with me, and there seems to be no contention with regard to the need for the data to be improved.

Secondly, I sent the letter jointly with Dr Buist, who is a GP in Blairgowrie—I am, of course, the non-clinician, but I have responsibility for the health service—not just because he carries a great deal of respect as a clinician and through his role in the BMA but because I wanted to make it clear that our joint expectation, which I think is the phrase that we use in the communication, is that the number of face-to-face GP appointments should increase, given the change in guidance. I promise Mr Rowley that I am keeping a close and very regular eye on the matter.

It would be unhelpful—Alex Rowley is absolutely not doing this—to try to pit one part of the health service against another, by saying that, for example, because GPs are not seeing people face to face, accident and emergency departments are having to pick up the demand. I caution against doing that and against suggesting—Alex Rowley is, again, not suggesting this—that GPs did not see patients at all during the pandemic and that surgeries were closed. GPs dealt with a high volume of cases. The Conservative spokesperson for health, who is a practising GP, speaks quite powerfully about the case load that he dealt with, let alone other GPs.

On the points that Alex Rowley raises, there is not much between him and me. I just ask that everybody exercises a bit of caution around this discussion.

10:45

Brian Whittle (South Scotland) (Con): I have three questions. The convener suggested that the number 1 threat to the health of the nation would be if the data-gathering and digital cybersecurity issue became serious. On the back of that, I want to look ahead in relation to Covid recovery, and probably further ahead than we have been talking about. I am interested in the impact on the Covid death rate of other health conditions. We are aware that conditions such as obesity, diabetes, heart disease and chronic obstructive pulmonary disease have a significant impact on the Covid death rate. I wonder whether it is time to rationalise that fact. Perhaps this is the time to draw a line in the sand and take a significant step forward on the preventative health agenda by tackling conditions such as obesity and diabetes, which will have the biggest impact on future death rates when there are pandemics, whether they are caused by Covid or something similar to it. What work is the Scottish Government doing or considering on that issue?

Humza Yousaf: That is an excellent question, although I am not sure that I would phrase it in the same way and talk about drawing a line in the sand because, prior to Covid, the Government—and, in fairness, the Parliament; we worked quite well and collaboratively across parties—made significant progress on the public health agenda. Significant progress was made on smoking cessation—I do not need to go into detail on the importance of that for reducing preventable deaths. Good progress was also being made on the ambition around obesity. I should say again that that issue was part of a shared four-nations agenda; I raised it with the other health ministers of the four nations. Although we have some issues with the UK Health and Care Bill, I agree with some of the public health policy that the UK Government is trying to introduce, particularly for tackling obesity and unhealthy food, on a point of principle. However, it has undoubtedly been the case that, because of the pandemic and our focus on Covid, we have had to pause some of the good work that we were doing. Certainly, the focus of our marketing and communications, which we have already spoken about, has absolutely been on getting information out about Covid, whether that has been about vaccines, good hygiene measures or something else.

What we have to do—I have spoken to Public Health Scotland about this in the not-too-distant past—is try to pivot back to some of those core and important public health messages. I think that that is what Brian Whittle was alluding to. He is right: the outcomes can be worse for people with Covid if they have other underlying health conditions. We have to understand the data on that a bit better; Professor Steedman can speak more to that from a clinical perspective. We will have to try to pivot back to those important public health initiatives and communications.

I know that Brian Whittle understands this fully, but I say to him that we are not out of the pandemic; we are still in the midst of it. I will not pre-empt today's figures, but I think that yesterday's figures showed that we still had between 2,000 and 3,000 cases a day. The figures are still extraordinarily high. If it were not for the effects of the vaccine and we were seeing the high case numbers of a year ago, we would be in lockdown.

Brian Whittle: Thank you, cabinet secretary. We are probably broadly aligned with regard to my line of questioning, but I am looking ahead at how we will come out the other side. Covid has exacerbated problems—for example, levels of obesity have increased. That brings me on to my second question.

The increased pressure on the NHS is, without question, part of the jigsaw. I was struck by the suggestion from one of our previous witnesses that the worst way to tackle mental health problems is to firefight and end up having to treat them with drugs. The other day, I asked the cabinet secretary about staffing issues, which have been exacerbated by Covid. There are many more absentees in our health service than there normally are. Many more students are applying for medical courses than there are places on offer in universities and colleges, and the Covid recovery will require significant long-term workforce planning. Where is the Scottish Government on collecting data on that and looking ahead to what the demand will be and how it will match that demand with a further increase in staffing?

Humza Yousaf: The NHS recovery plan, which is our plan for the next five years and is backed by £1 billion of investment, as Brian Whittle knows, provides a high-level overview of what we intend to do to increase the capacity for in-patients, out-patients, diagnostics and treatment for cancer and mental health, for example. I will not rehearse what is in that plan, because it is available for everyone to see.

The point about long-term planning is really important, because the NHS faces an immediate challenge, an immediate crisis and immediate pressures. That also applies across social care. We are dealing with those things, but it would be wrong not to think about the long term, which is why we have committed to producing a workforce strategy by the end of the calendar year. Trade unions and staff-side representatives will, of course, be integral in helping us to understand the challenge.

The strategy will need to show a degree of flexibility because, frankly, we do not yet fully know what the indirect health impacts of Covid-19, which Alex Rowley spoke about, are. That is because, as I keep saying, we are still in the midst of the pandemic.

Everything that Brian Whittle said about the health impacts and the scale of the challenge that we face was absolutely right. I often say in the chamber that Covid-19 is the biggest shock that our NHS has faced in 73 years, not just because of its direct impact, which is huge and significant in its own right, but because of the indirect impacts, which will last for years. I always do my best to be up front with the public in saying that we cannot expect to solve those problems in the space of weeks or even a couple of months, because it will take years to do so. That is why our recovery plan is a five-year one.

On the points that Brian Whittle raised the other day about the number of entrants into specific courses, we are working hard on that with schools and higher and further education institutions. Our fill rate is good, as we saw from statistics that were

released recently. However, if we dig deeper into those statistics at a more granular level, we begin to see where we need to do a bit more work. Brian Whittle was therefore right to raise those issues in his question.

There is simply no doubt that mental health challenges have been exacerbated by the pandemic. That is not to say that there were not challenges before the pandemic. There were significant challenges, but they have been exacerbated.

I have been saddened to see, even in my constituency, the number of people, including young people, who have completed suicide over the course of the pandemic. I had not seen those numbers in my constituency in past years, so that has been extremely saddening. Other members could probably say the same. Although we are funding crisis interventions, for example, in our child and adolescent mental health services, we are also funding pre-crisis interventions and initiatives at a community level, to stop people getting to that crisis point.

Professor Nicola Steedman: The cabinet secretary mentioned that I might be able to add more information about what we are doing in relation to underlying determinants of health and public health, such as exercise, diet and alcohol issues. I concur that many of those underlying determinants of health have worsened and become more polarised because of the Covid pandemic. We often find that pandemics affect those whose underlying health is poorest in the first place. We are acutely aware of that, and health improvement through improving those underlying determinants of health is one of the pillars of our Covid recovery strategy for Scotland.

The committee will be aware of the remobilise, recover, redesign programme, through which we have four different programmes of work. I highlight that one of those specifically relates to proactive and preventative care; in other words, it aims to address those fundamental underlying determinants of health. We view that as so important that we have devoted one of our four major care programmes to it. The CMO's report this year highlighted his particular commitment to focusing on health inequalities in Scotland, which are largely determined by those underlying reasons for poor public health.

We will be supported in that endeavour on the proactive and preventative care approach by Public Health Scotland, which highlighted many of the domains within that health improvement programme in its delivery plan for 2021-24. There is a great awareness of the issue among clinicians in Government and ministers, including the cabinet secretary. We are highlighting that as an important issue not just in relation to recovery from the pandemic but in improving Scotland's public health across the board and increasing our life expectancy, which we knew before the pandemic was probably among the worst in Europe. The committee member has rightly raised a huge issue.

Brian Whittle: The cabinet secretary talks about the acute response to Covid that is currently required. We cannot overstate how important that is, but I want to consider where we will move to after that.

I go back to data gathering. Data is important to the longer-term study of the impact of Covid. I am interested in the impact on the black, Asian and minority ethnic community, the fact that we have a smaller BAME community here than there is down south, and whether that has had an impact on the numbers. We have a fairly poor health record in Scotland. I am interested in what impact that has had on the Covid data. We have talked about ethnicity in relation to the uptake of the vaccine and the variation in uptake in Scottish index of multiple deprivation areas.

If we consider the reactions of Governments at the start of the pandemic as the virus made its way across the world, we would agree that Governments did not react as quickly as they could have. All that data needs to be gathered.

Where are we on data gathering and pulling together all those issues to look at how we will come out of the other side of the pandemic and how we will prevent, as much as we possibly can, something similar happening again?

Humza Yousaf: Those are excellent questions and very good points. We are doing a lot of that work. We have been guided in a lot of our consideration of ethnic minority communities by an expert group that was being led by Christina McKelvie, who is on a period of curative leave. Other ministers are taking over that work. It involved a number of organisations across Scotland that will be familiar to Brian Whittle and committee members who represent our ethnic minority communities. They have given a number of recommendations to the Government, which have, I think, been published—forgive me; I will double check that. Many of their recommendations focus on data.

We are not where we want to be on data, particularly in relation our ethnic minority communities. That applies across the Government and the public sector. I remember that, when I spoke about justice outcomes for ethnic minority communities when I was Cabinet Secretary for Justice, we did not have the data that we wanted at a granular level. A lot of work is going into improving data, particularly for ethnic minority communities.

11:00

I do not disagree with the points that Brian Whittle raised. We take a great interest in some of the studies that have been done across the United Kingdom, but there are some nuanced differences between Scotland and, say, England when it comes to BAME communities. In my experience, there is a difference between the south Asian Pakistani community in Scotland and the Pakistani English community in Bradford, for example. I am not sure that I have ever got to the nub of the reasons for that, but there are differences in economic status and so on. We have to be aware of such differences.

Lots of good studies are being done globally. We do not just take an interest in those studies; we actively seek out those that are on-going and anything that we can learn from them.

I do not disagree with Brian Whittle's central point about data. We are doing a lot of work to try to improve our data collection in the longer term to inform our future response.

John Mason (Glasgow Shettleston) (SNP): I want to return to the question of the different vaccines and their impact. A suggestion was made some time ago that it might be beneficial to mix vaccines so that people got two different ones, or that the third shot should be different from the first two. Are we any further forward on that?

Humza Yousaf: I should probably let Professor Steedman come in on that point. We have the preliminary results of the Cov-boost clinical trial, which have informed the JCVI advice in respect of the booster programme. For that reason, for the booster dose, we are using mRNA vaccines—Pfizer or Moderna vaccines. The results have not yet been published, but will probably be published by the appropriate bodies later this month.

I throw into the mix the fact that several clinical trials are under way with vaccines that are currently not being used. However, before I overreach myself, I will bring in Professor Steedman.

Professor Steedman: A lot of data is emerging on the mixing of different types of vaccines. That is important for a variety of reasons. It will simplify roll-out of the vaccination programme if it is possible to mix and match different vaccines and, more importantly, the mixing and matching may produce a greater clinical response, which is what we have been focusing on. The cabinet secretary is correct that the JCVI advice on the preferential selection of mRNA vaccines for the booster programme is based on that mix-and-match data, which suggests that if we boost with an mRNA vaccine—at the moment in the UK, that is Pfizer or Moderna—we will get an incredibly high antibody level response and potentially a broader response, too.

That is why that data is being used to inform the vaccination programme. It is important to note that both types of vaccine that we use in the UK for the primary vaccination programme—the AstraZeneca vaccine and the mRNA vaccines—are incredibly good at preventing severe disease. I know that there has been some concern among the public about which vaccine they are getting and whether they are getting a good vaccine or a not so good one, but both those types of vaccine are incredibly good at preventing hospitalisation and severe disease and we are very fortunate to have them. As for the booster, it looks like, no matter whether someone has had an mRNA vaccine or the AstraZeneca adenovirus vaccine, an mRNA booster seems to produce a really high response. That is why it is being used for the booster programme.

I do not want to labour the complexity of this, but there are differences between a primary course of vaccination—that is, the initial two or, in some cases, three doses—that gives the initial priming response, and what is used for the booster. At the moment, we still recommend that, in most cases, the same vaccine be used for the two doses of the primary course and that an mRNA vaccine be used for the booster.

Finally on the mixing of different types of vaccines, another thing that is being closely monitored is whether giving different types of vaccines produces different or greater side effects, which is something that the public is rightly concerned about. Again, this is an incredibly complex issue, given the number of different ways in which the mix of vaccines can be administered but, ideally, we are looking for the best possible immune response with the fewest side effects. That is why the vaccines have been mixed and matched in the way that we have recommended. Using the same vaccine for the primary course minimises the side effects, while the booster gives a greater effect overall and broader protection while minimising any increase in side effects that people might have from mixing the vaccines.

John Mason: I appreciate that good and quite detailed answer.

I do not know whether this is typical, but I know of a constituent in their 50s who refused to have AstraZeneca and instead wanted Pfizer, which, although approved for his age group, was being used for other age groups, and another younger person who went to a drop-in centre, got Moderna for his first jab and now cannot find anywhere that will promise to give him the same for his second. Those two people could be fully vaccinated if there were a bit more flexibility but, of course, we do not

want to be too flexible. What is your reaction to that situation?

Humza Yousaf: Before I answer the question, I should say that you should contact the health board if there are particular issues that you feel it should look at, but I am, of course, happy to explore the issue as health secretary if you want me to.

You are right to suggest that there is a balance to be struck. We want to get as many people as possible fully vaccinated, but if we allowed everyone to choose their vaccine, we could have supply issues that would give us real worry and concern. When some of the initial data came out about AstraZeneca and the potential for side-effects, particularly blood clots, in the under-40s, a number of people, some of whom were over 40, wanted the Pfizer vaccine, and we had to take a robust line if we did not want to run into supply issues. I think that we have struck the right balance at the moment, and I think that that view is justified when you look at the percentage of people who are fully vaccinated.

John Mason: I suppose that my question was about how we mop up the remaining people.

Humza Yousaf: I take your point, and it is a good one, but I think that we have got the balance right. There is a degree of flexibility. However, it might be better if I bring in Professor Steedman and ask whether she has anything to add.

Professor Steedman: The cabinet secretary is absolutely right. At the programme's inception, and with the constraints on the supply of vaccines, we had to ensure that we were able to vaccinate the entire adult population at that time. That meant clinically directing vaccines at certain age groups where there were greater benefits for the age group in question or a lower risk of any potential adverse effects. I absolutely supported that move as the right decision. I received the AstraZeneca vaccine as part of the programme, turning up as an over 40. That was the right thing to do.

I stress again that both types of vaccine are incredibly effective at preventing severe disease and death—we must remember that. Having said that, there is now less of an issue with the supply of mRNA vaccines. In fact, because the booster programme will use mRNA vaccines pretty much exclusively, it is less of an issue. If, for example, someone turns up who might previously have been in the age group to receive an AstraZeneca vaccine but the clinic has and is giving only mRNA vaccines, the board has flexibility to use the mRNA vaccines in people who would otherwise not be vaccinated.

We want everyone to be vaccinated but, as the cabinet secretary says, we cannot have people just coming in and saying that they want this or that vaccine. We would not recommend vaccines for groups, and the Medicines and Healthcare products Regulatory Authority would not authorise vaccines for groups, if they were not deemed to be safe and effective. However, for operational reasons, there is a degree of flexibility that now means that it is more likely that people will receive mRNA vaccines if they come for a primary vaccination course. That might reassure some members of the public.

We can follow up the Moderna issue separately with the health boards because, as the Moderna vaccine is also recommended—albeit in a half dose—as part of the booster programme, many clinics should be providing that vaccine. I emphasise that, if a particular vaccine is not available, it is possible from a clinical point of view to mix and match the vaccines and to complete the course with another one. That would not be hugely problematic; it is just that, as I said, it can sometimes increase the side effects for someone, so we always try to do the primary course with the same vaccine and will try to organise that for anyone who has difficulty accessing it. It is more important that people get two doses of vaccine.

John Mason: I will touch on the role of the JCVI. On the whole, we followed its advice pretty slavishly, as all the UK countries did, until we got to the 12 to 15-year-olds, when there seemed to be a bit more wriggle room. As I understand it, the chief medical officers decided that bringing in the education considerations would lead to a different decision. Does that change the relationship with the JCVI or was it an exception? How are we looking at it?

Humza Yousaf: I slightly disagree with your characterisation of what happened—I would not use the word "slavishly". The members of the JCVI are the experts in vaccination and immunisation. It is important that every Government listens carefully to what the JCVI has to say, but that does not mean that we do not scrutinise its advice where necessary and appropriate. That is the same for every Government across the four nations.

If you look at the advice on 12 to 15-year-olds, you will see that the JCVI itself recommended that health secretaries task their CMOs with considering the wider implications. Therefore, I would not say that we moved away from its advice. It was the JCVI that pointed out that its remit related only to health and that there was a marginal health benefit to vaccinating 12 to 15-year-olds but not enough to suggest a universal offer. Therefore, it advised us—the Governments—to task our CMOs with considering the broader implications of educational disruption. The CMOs did not just make that decision themselves. They spoke to the Royal College of

Paediatrics and Child Health and other bodies over a number of days, as you would imagine, and then recommended a universal offer for 12 to 15-year-olds.

The decision does not change the dynamic. Although the Scottish Government does not have the same obligations as the UK Government has in relation to JCVI advice, we still put weight on it and stock in it. The JCVI has sometimes given advice that has perhaps gone against the tide of public opinion but has proven to be right, such as the eight-week gap between doses 1 and 2, which is different from the approach in a number of other European countries.

In Israel, for example, the fact that restrictions had to be reimposed was, certainly initially, put down to the fact that the gap between dose 1 and dose 2 of the vaccine meant that not so many people had maximum protection as was the case in the UK, because we followed the JCVI advice on the eight-week gap between doses, which we think afforded greater protection. I do not think that the value of the relationship has changed, and we put great stock in its advice.

11:15

Alex Rowley: On Tuesday, the First Minister said that the advisory sub-group on education and children's issues was due to meet and review whether the restrictions in schools should continue unchanged. Did that meeting take place? I might have missed the announcement.

Humza Yousaf: I assume that it met. Forgive me, but I have not seen the outcome. As the member knows, the First Minister made her statement on Tuesday so, if there were any significant announcements to make, I am sure that she would have made them. My officials might wish to add something, but—

Alex Rowley: The First Minister said that it might well recommend keeping the mitigations in place for longer but that the group would consider them that afternoon. A lot of parents write to us about those issues.

Humza Yousaf: There have been no changes to the mitigations in place for children and young people. In fact, if anything, we are trying to progress activity on ventilation in schools at quite a pace—we are looking to do that at an even greater pace. As I mentioned, I am a parent to a 12-year-old who has just started high school, and we know that the mitigation measures, particularly the use of face coverings, are difficult for young children. However, there have been no changes to the mitigation measures. If there is an update, I will be happy to provide it to the convener.

Alex Rowley: Could the committee get an update, and could we have a progress report on the steps that are being taken to make schools safer for kids?

Humza Yousaf: Yes. On the ventilation point in particular, we will be happy to provide updates.

The Convener: I will go back to John Mason's point about the roll-out of the booster vaccinations. Is it likely that we will all have booster vaccinations every six months? Is there any concern about vaccine supply?

Humza Yousaf: There are no concerns about supply at the moment. The supply system is working well. In my time as health secretary, the relationship with the other four nations has been really positive. I put on record my thanks to Nadhim Zahawi in particular, who, following his time as Minister for COVID Vaccine Deployment, has rightly been elevated to Cabinet level. He was very engaging and accessible on vaccine issues and we exchanged messages often whenever there were any issues. As you can imagine, I have also had good meetings with manufacturers. There are no supply issues, including for the booster programme—that is all fine.

We continue to wait for JCVI advice on several areas, including boosters for the rest of the population. It has given us advice on priority groups 1 to 9, as they traditionally were, which we are taking forward. We are still waiting for further advice, so I do not want to pre-empt that. However, the issue of boosters for the rest of the population is under active consideration.

The Convener: I will bring in Jim Fairlie briefly.

Jim Fairlie: We are still getting inquiries from people who had their first vaccination somewhere else in the UK and are getting their second one in Scotland. Are we any closer to a solution for that issue?

Humza Yousaf: I accept that the cross-border issue can be challenging, depending on whether someone had their first dose in Scotland and their second dose in England, or their first dose in England and their second dose in Scotland, or whether they were outwith the common travel area and so on. With regard to the certification scheme, people's proof of being vaccinated—whether it is the English app or a paper copy—will be accepted. People will not be turned away from the football, a late night venue or wherever else.

We have a bit of a challenge with updating records for what are termed orphan records—those who had a dose in England but who do not have an NHS number, which is the equivalent of our community health index number. That issue has to be resolved with NHS England. Once a person has that number, the issue can be

resolved. I might bring in Jonathan Cameron to give an update on the portal, which we hope to launch either today or very shortly. The portal will allow people to upload their record, and then the issue can be resolved at the other end.

Jonathan Cameron (Scottish Government): The portal is ready. We are preparing the necessary communication and it should be launched on Monday.

Humza Yousaf: We hope that the portal will help with that issue.

The Convener: Thank you. That concludes our consideration of that agenda item and our time with the cabinet secretary. I thank him and his supporting officials for their attendance.

The committee's next meeting will be on 28 October, when we will take evidence from the Cabinet Secretary for Net Zero, Energy and Transport on the ministerial statement on Covid-19 and subordinate legislation.

That concludes the public part of our meeting.

11:20

Meeting continued in private until 11:40.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba