OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 28 October 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 28 October 2021

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COVID-19 RECOVERY COMMITTEE

8th 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:

Graeme Dey (Minister for Transport)
Professor Jason Leitch (Scottish Government)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 28 October 2021

[The Convener opened the meeting in private at 10:15]

10:31

Meeting continued in public.

Decision on Taking Business in Private

The Convener (Siobhian Brown): Good morning, and welcome to the eighth meeting in 2021 of the COVID-19 Recovery Committee. I apologise for the slightly late start this morning.

The second agenda item is a decision on whether to take item 5, which will be consideration of evidence, in private. Do members agree to take item 5 in private?

Members *indicated agreement.*

Ministerial Statement and Subordinate Legislation

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Regulations 2021 (SSI 2021/322)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment Regulations 2021 (SSI 2021/328)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/343)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 3) Regulations 2021 (SSI 2021/350)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 4) Regulations 2021 (SSI 2021/357)

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/359)

10:31

The Convener: Agenda item 3 is evidence on the latest ministerial statement on Covid-19, and on subordinate legislation. I welcome to the meeting our witnesses from the Scottish Government. Graeme Dey is the Minister for Transport, Professor Jason Leitch is the national clinical director, Penelope Cooper is the director of Covid co-ordination and Graham Fisher is a deputy director in the Scottish Government legal directorate. Thank you for your attendance this morning.

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

The Minister for Transport (Graeme Dey): Thank you, convener. I will briefly address the instruments that the committee is considering today, taking them in order.

Since coming into force, the international travel regulations have been amended extensively, and were contained in several instruments. The Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Regulations 2021 consolidate them into one, and did so on expiry of the existing regulations on 20 September.

A number of structural and drafting changes have been made with the intention of improving readability and intelligibility of the regulations. There have been a further five amending instruments to the regulations. Following the regular four-nations review of analysis by the joint biosecurity centre, the first amendment, which is SSI 2021/328, moved Bangladesh, Egypt, Kenya, the Maldives, Oman, Pakistan, Sri Lanka and Turkey from the list of red countries to the list of amber countries.

As Scotland and other countries continue to respond to the challenge of the pandemic, vaccines have played a key role in allowing international travel to open up to a greater extent in a safer way. For people arriving in or returning to Scotland who have been vaccinated in Scotland, the option of providing evidence of having been vaccinated was previously limited to showing a paper certificate. In addition to the paper and downloadable PDF version of the vaccination certificates that are issued by NHS Scotland, the number 2 amendment regulations—SSI 2021/343—enable the NHS Scotland Covid status app to be used as proof of vaccination status, in recognition of the shifting landscape of international travel and vaccines, as well as a new framework for assessing the risk that is posed from other countries.

The four nations collectively agreed to overhaul the international travel policy to make it more straightforward and responsive to the current public health landscape. The new travel regime that will be implemented by the number 3 regulations—SSI 2021/350—abolished the traffic light system for all but the highest risk red-list countries. For the vast majority of cases, travellers will be subject to border health measures based on whether they meet the eligible vaccinated travel criteria, rather than on which country they have travelled from.

Eligible vaccinated travellers will no longer be required to take a pre-departure test or to self-isolate for 10 days upon arrival, with all others still being required to do so. Travellers arriving from a red-list country, regardless of vaccination status, are still required to book into managed quarantine facilities, and the associated testing regime remains in place, given that those countries have been assessed as posing the highest risk.

Other changes that were introduced by the instrument include accepting more countries' vaccination programmes for the eligible vaccinated travel policy and amending the obligations on carriers following the introduction of the new regime. New arrangements were put in place for cruise passengers, given the restarting of international cruises, and there were some minor sectoral exemptions and specified competition additions.

The number 4 regulations—SSI 2021/357—made more countries' vaccination programmes eligible for the new policy, in addition to recognising individuals who had been vaccinated through the United Nations vaccine programme, and allowed for the European Union digital Covid certificate to be used as proof of a negative pre-departure test. The regulations also significantly reduced to seven the number of countries on the red list.

The spread of the delta variant across the world and its interaction with previous variants of concern mean that many countries have been assessed as posing no additional heightened risk to the United Kingdom from international travel. The countries that remain on the red list are all in central America and South America and the Caribbean. Delta has been slower to reach that region than it has elsewhere in the world, and there are still variants of concern there, particularly the lambda and mu variants, about which we do not yet have sufficient evidence of interaction with delta to reduce the risk assessment.

The SSI also made a number of changes to cater for the arrivals to the 26th United Nations climate change conference of the parties—COP26—where bespoke travel arrangements based on public health advice have been agreed with the UK Government and the United Nations Framework Convention on Climate Change in order to hold a successful conference in Glasgow.

The number 5 regulations—SSI 2021/359—made further amendments to the eligible vaccinated arrival policy, including the provision to include among eligible vaccinated arrivals a person resident in Scotland or England who has not been vaccinated on medical grounds. That amendment was the outcome of the on-going review of the scope of the exemption for eligible vaccinated arrivals, with regard to which we have been particularly conscious of the policy's equalities-based impacts, particularly on those who cannot be vaccinated for medical reasons. There have also been further amendments to clarify the position for COP26 participants and on the diplomatic exemption in the regulations.

The Convener: Thank you, minister.

We now move to questions, and I will ask the first of them. The committee is currently trialling an online platform to allow members of the public to put forward questions that the committee can ask in evidence-taking sessions, and one such question is about global collaborative working. Why are all countries not following the same travel rules? The questioner feels that, if there had been

a global approach, the spread of the virus could have been better controlled.

Graeme Dey: I think that I should bring in the expert here.

Professor Jason Leitch (Scottish Government): I genuinely think that that is a really good question. I should also say that I like the committee's innovation, which I think is a good development.

The challenge, of course, is that there are 6 billion people in the world and 200 and something countries, and it would be pretty much impossible to manage all that. Actually, I think that co-operation globally has been outstanding and, indeed, quite surprising. My piece of the puzzle is the provision of clinical advice, as led by the World Health Organization and reflected not only in each continent through, for example, the European Medicines Agency in Europe, but in the clinical collaboration UK-wide and in Scotland. The approach to that has been exceptional. We have pretty much given the same advice across the UK. How Governments choose to take and use that advice is, of course, a matter for them, but we have based it on what the WHO has said. However, the WHO has an incredibly difficult job, because it has to give advice not only to Scotland but to, say, Zambia and Indonesia, which have very different health systems and demographics.

That brings us to the travel challenges. The management of travel is only part of the response to the global pandemic, but countries' approaches to it vary hugely. Clearly, New Zealand is the poster child for international travel restrictions, and its approach has served it well, but it is a relatively isolated part of the world and does not have a massive airport such as Heathrow or those in Berlin or Chicago. Each country has to apply the clinical principles more locally in whatever they do.

Therefore, the premise of the question is good, but what it suggests is a bit tricky to do at the global level.

The Convener: People can now download the digital vaccination passports that show when their vaccinations took place. As we know, some people are unable to travel, such as teenagers who have not have their vaccination and those whose PCR—polymerase chain reaction—test may still come up positive even though they had Covid weeks ago.

Is the possibility of adapting the current digital app being explored? For example, if somebody gets Covid, that information can go into the app. If they have had two vaccinations, and they got Covid on 1 October—the national health service would know that if the person had been pinged—the app would have that information and, moving forward, it would also contain their history of booster vaccinations.

I am sorry if that is a bit technical, but I am concerned that some people are currently unable to travel because they had Covid previously and their test is still coming up positive even though they are no longer positive.

Professor Leitch: That problem is overstated, but there are instances of it. The headline is that someone can still be positive 90 days after they have had Covid, but that is very unusual—it is much more likely that they will have a negative PCR result after only a matter of weeks.

There are some examples in the literature of people who have still tested positive because they are still shedding dead viral particles after 90 days. The difficulty is that we do not control other countries' entry requirements—we control only our own. Some countries demand a negative test. That puts us in a difficult position, because we cannot get the individuals whom we are talking about a negative test—it is impossible. Until the testing technology has moved on and gives us something new, we cannot get those individuals a negative test. However, I say again that we are talking about a very small group of people. We can be ready with the technology when the policy position changes, for instance, to include testing or previous disease—we could adapt the technology to take account of that. We could not do that in 24 hours, but the technology could be adapted.

Other countries have passports—for lack of a better word—that look a bit more like that, as they contain information on testing. However, let us remember that if Norway, for example—I choose that country randomly, not because there is a problem—wants a negative test and somebody is still getting a positive PCR result, there is nothing I can do about that.

The Convener: My last question—it is for you again, Professor Leitch—is to do with symptoms of the virus and the conflicting information that is currently in the public domain. On 22 October, the British Heart Foundation updated the Covid information on its website. It says:

"The main Covid-19 symptoms if you are fully vaccinated"

are

"a headache ... a runny nose ... sneezing ... a sore throat"

or

"a loss or change to ... smell."

However, the symptoms that the website lists

"if you are not fully vaccinated"

still include

"headache ... runny nose ... sore throat ... fever"

and

"a persistent cough".

There seems to be a bit of a conflict between the guidance from the UK Government and the Scottish Government and the information that other bodies are putting out.

Professor Leitch: There is, and there has been for two years. There are 19 symptoms of Covid-19, all of which present in other diseases, so that gives us a big challenge. Unfortunately, someone does not get a 10p piece-sized rash on their wrist that confirms that it is Covid. They get a vague and broad set of symptoms, which could be the result of many other diseases. Some people get only gastrointestinal symptoms, or only the loss of taste or smell.

There are roughly 19 symptoms, and we get clever people to work out which of those symptoms are most likely to give us the right balance between testing, isolation, disease and so on. That is a very difficult formula, and those people have stuck with the three cardinal symptoms: fever, cough and loss of taste and smell. Those cardinal symptoms have stayed consistent throughout almost two years. Every few weeks, they look again and say, "If we added headache to the list, what would that do? How many people would have to self-isolate, how many PCR tests would have to be done and how much disease would we find?"

Do you see what I mean? It is not an exact science—they make a judgment. To this point, the judgment has always been that the cardinal symptoms should stay the same. That does not mean that people should ignore other symptoms—there is advice online about what to do if people have other symptoms—but the cardinal symptoms are the ones that should, in the United Kingdom, lead them down the PCR testing route. For everything else, let us do two lateral flow tests a week. That will find out if someone has Covid, because the frequency of the testing will still find the disease.

10:45

Murdo Fraser (Mid Scotland and Fife) (Con): To continue with the convener's theme of public engagement, members of the public have also raised the issue of COP26, which will happen next week and the week after. Up to 100,000 people will converge on Glasgow. Some of those who are travelling internationally to attend the main conference may not be double vaccinated. There is therefore a risk of further spread of Covid.

The public would like to know what mitigations have been put in place to avoid further spread of Covid at COP26 events. Has the Scottish Government carried out any modelling of the possible increase in case numbers as a consequence of COP26?

Graeme Dey: There have been extensive preparations for the COP and there will be a range of measures, which Jason Leitch can outline in detail. As someone who will be attending the event, I am impressed by the range of measures in place. Those are tailored to delegates' different circumstances. Jason can give you the full detail.

Professor Leitch: As you can imagine, we have been planning this for some time. Two years of that planning process have been during the pandemic. The event was postponed from last year, so we already had a lot of plans in place and, now, here we are—the event will happen this week. There are already some delegates at the Scottish Event Campus. I made a final Covid safety site visit earlier this week. The campus is as impressive as you would expect it to be, although there are not many human beings there yet. That is the variable that will be added this weekend.

There are three zones. The blue zone is for the 26,000 delegates. There will be a maximum of 14,000 delegates inside the SEC at any time. Some of the headlines about numbers are rather deceiving. The space inside the SEC has been trebled by the use of temporary structures. In that huge complex, at any one time, there will be up to 14,000 people. Almost all those who are in the blue zone will be vaccinated. At last count, around 90 per cent had been. We do not know everyone's vaccination status, but the numbers are high. With our help, the UK Government has reached out to those from the global south who are unvaccinated and vaccination has been offered to all registered delegates.

Everyone will wear a face covering, except when they are speaking in negotiation rooms like this one. If people are walking around or are in social areas, except when they are eating or drinking or when another exemption applies, they will wear face coverings. There will be 1m distancing as far as that is possible, although there will be 14,000 people in the SEC. Those of you who know that place will be aware that there are pinch points where distancing will be more difficult, but there will largely be 1m distancing. There will be all the hygiene measures that you would expect.

There are layers of security on the way in. The unique measure that does not happen in the rest of Scotland is that people will have to show evidence of a negative lateral flow test in order to be allowed in. I will be going there again this afternoon to take part in a gold command meeting and I will have to show the result of a lateral flow test that I did this morning to get through the first layer of security. No one will get through the first outdoor gate if they do not have a negative test

from that day—not yesterday, but that morning. That applies to all delegates in the blue zone. I am not overly concerned about the blue zone. I cannot give a guarantee, but it is as secure as we could make it, given the circumstances.

Those in the green zone and the protesters and activists beyond that will have to follow the rules that are in place in Glasgow at the time, which we all know. That area worries me more. We are not entirely sure where all those people are from, and we have less control. We cannot lateral flow test all of them every day, I do not know their vaccination status and so on. Those large gatherings have always worried us more, as you would expect. They will be subject to the same rules that you and I would be subject to if we walked down Sauchiehall Street tomorrow.

Murdo Fraser: It is helpful to understand the mitigations. The part of my question that you did not address was on the issue of modelling. People are concerned that we might see a spike in cases and that further restrictions might be brought in for people in Scotland as a consequence of a spike in infections caused by the COP.

Professor Leitch: We have done autumn and winter modelling. It is pretty much impossible to model the COP, because it is too complex and there are too many people from too many countries, which creates too many variables. The next few weeks of modelling, which is the material that we publish every Friday, do not show a particular spike, but any spike from the COP will not happen next Tuesday. The spike from COP could be in this country or abroad: we could export virus as well as import it. Any spikes that other countries take home would not happen until about two or three weeks later because of the incubation period.

Our present modelling does not indicate a spike after COP, but I cannot guarantee that there will not be one. I also cannot guarantee that a spike would need a reverse gear. You would not expect me to be able to do that. If the First Minister asked me today what my advice would be, I would say that we should stay where we are, but if the numbers go up that advice will change.

Murdo Fraser: Basically, you are saying that there is a risk.

Professor Leitch: Of course. Yes, there is a risk.

Graeme Dey: As we have heard, there is also the creation of a culture and a mindset around the situation from the measures that we have put in place. We are trying to make it clear to as many participants as we can what measures need to be followed, whether within COP26, when they are using public transport or whatever. Everyone needs to be mindful of the need to look after themselves and the people around them to minimise that risk.

Alex Rowley (Mid Scotland and Fife) (Lab): How are the booster jags going? [*Laughter.*]

Professor Leitch: The booster jag process is going remarkably well. On the day that the Joint Committee on Vaccination and Immunisation announced booster doses, hundreds of thousands of people were already eligible. We cannot do them all in a day; that would be impossible. Tens of thousands of NHS workers around the country are vaccinating people today. It is the biggest winter vaccination programme in history, so I am enormously grateful to every single volunteer, from those in the hospital on Orkney to those in the Queen Elizabeth university hospital, for everything that they have done over the past while. We have vaccine and we have vaccinators, so we will get to those people.

Some of the narrative around the situation is plainly not correct. People's immunity does not stop at 24 weeks; it does not suddenly fall off a cliff so that people will get Covid because they have not had their booster dose. The JCVI has said that we should not give booster doses until six months have passed because it wanted to get maximum benefit from elongating the time for which people would get immunity. The JCVI said that booster doses should be given from six months onwards; we are doing that as quickly as we can.

We gave 8 million doses of the current vaccine in nine months. We are now trying to do 7.5 million doses in four months. It is a remarkable exercise; nobody has ever done anything like it before and it is going really well.

Alex Rowley: I appreciate that. Most MSPs will be getting correspondence from people about the boosters. I saw a couple of pieces of correspondence yesterday. One was from a person who had gone to the website where they saw that they had an appointment in a couple of days. However, they were still waiting for a letter, so there seems to be a problem there.

I also note that boosters for over-80s in Cowdenbeath and Lochgelly are not due until November at general practices, but people who are in their 70s will be getting their boosters before that, even though the over-80s are more at risk.

Is there a specific minister or email address to which MSPs can channel such issues? We seem to have to go round the houses. If we go to ministers, we do not get a response for weeks or sometimes months. If we try to go through our NHS board, we are sent to a website. The situation is a real worry for people in their 80s and 70s, so is there something that we can do to ensure that people who have concerns have

somewhere to take them where they will get a response?

Graeme Dey: I will deal first with ministerial responses. I noticed the finger pointing in my direction when you were talking about ministerial responses. I hope that what you described is not the case for me; I like to think that my correspondence is turned around very quickly. I am sure that you will tell me if that is not the case.

When I was Minister for Parliamentary Business in the previous session of Parliament, we set up dedicated contact points within Government. I do not mean this as a criticism of MSPs, because they were trying to help their constituents and it was a pretty fraught time, but one of the problems that arose was that the same email was going to three or four different mailboxes, which was creating difficulty in the system. Jason Leitch might say something in a minute, from his point of view. I will mention to the Minister for Parliamentary Business that what you suggest might be helpful. I will ask him to have a chat with health colleagues and then to share with MSPs what is decided.

Professor Leitch: You can be absolutely certain that I get copied into almost all the emails that go to all MSPs about the challenges, so I get them from 129 sources. We are doing our best to work our way through the challenges. In a system in which we are vaccinating 7.5 million people, of course there will be some people whose appointment is put online before they get the letter through the mail. Those people should go to the appointment that is shown online, if they know when it is. I apologise if the system is not as smooth as people would like.

For instance, my parents, who are 80 and live in Lanarkshire, were vaccinated in Airdrie town hall when they had their flu jags, and the process could not have been smoother. That was not because of who their son is. There are stories like that from all over the country—of things going really well and of the NHS working really hard. However, I agree that if there are specific issues, such as Alex Rowley's people in their 70s versus people in their 80s story, they are worth investigation. If you want to send the information to me, I will get somebody to look at it for you.

Alex Rowley: Thank you. Everybody understands that the NHS is under immense pressure. Staff are, frankly, under too much pressure. Something will have to give at some point, if we do not get a hold of things. You can understand the worry for people in their 70s and 80s.

I will pick up on death rates. It was said this week that the number of deaths registered in Scotland from all causes was 24 per cent more than the five-year average. I know from people who have contacted me after having struggled to get a GP appointment or to see anybody in a medical centre that they have eventually presented themselves at the hospital, where they have found out that they have cancer or something, and that it has moved on by some stages. Are you aware of that? To what extent is it an issue? Are you monitoring it? Are excess deaths a result of community and other parts of our NHS being shut down? Where are we in relation to general practices giving people appointments when they say that they need an appointment because they feel ill?

Professor Leitch: That is a genuinely difficult matter. Excess mortality is a notoriously challenging statistic. It is historical and it is retrospective; it uses previous years and—please forgive the shorthand—works out the number of people who should have died. The number is extrapolated to the next year, when we monitor how many people died. The statistic compares the expected death rate with the actual death rate. It is a horrible way to think of it. These are real families and people—my family and your family—but that is how the statistic works.

Excess mortality has varied during the pandemic in every country in the world. We have seen excess mortality because people have died of a new infectious disease. Unpicking the number from the people who have died because of the response to the disease—whether they are in India or Scotland—because of late diagnosis of cancer, or because of a stroke or whatever else, is incredibly difficult, so we do not know the causes of the excess mortality.

In the past few weeks and months, the rate has ticked up again because we are in a third wave of Covid and Covid deaths are higher. Remember that in the previous five years we had no Covid deaths. We have a new disease but we have not taken away anything else that is killing people. The excess mortality figures will only help us historically; we will eventually get into that.

The questions about what the health service will do are not for me, but for ministers. I can tell you that general practices are open and have been throughout the pandemic—they are one of the few pieces of the societal puzzle that has been open throughout. They have had to make some difficult choices about who to see, who to see online and who to deal with in with phone calls. I am hugely grateful to my colleagues in clinical general practice—the broad teams, including the doctors and everybody else.

Face-to-face treatment is here; it never went away. Some people get face-to-face appointments. Decisions about who gets them are based on safety and on the health of the

individuals. They have to be clinical decisions that are made locally.

Alex Rowley: I know that we need to move on, but that is not the experience of people out there in communities. People who are feeling ill are finding it difficult to get face-to-face appointments.

Professor Leitch: Some people are.

Alex Rowley: Some people, but—

Professor Leitch: That is not the experience of the whole community.

Alex Rowley: What if it is someone in your family who has been trying to get an appointment but cannot get one, who might discover, when they eventually get to the hospital, that they have stage 2 cancer, or whatever, that could have been diagnosed earlier? The issue is coming up again and again: people are struggling.

I understand that a letter was sent from Dr Buist and the Cabinet Secretary for Health and Social Care to GPs, but it is not just about clinical choice; there is a responsibility on the Government. When people feel ill and feel that they need to have a face-to-face appointment with a medical person, it is the responsibility of the Government to ensure that those people can access face-to-face appointments. Surely that is the case, minister?

Graeme Dey: That is also determined through the clinical judgment of GPs from conversations with people, perhaps over the telephone. Ultimately, a GP will make a decision based on that consultation.

I acknowledge your point, Mr Rowley, but we are in very difficult circumstances.

11:00

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Good morning, Professor Leitch and cabinet secretary. I have various queries on subjects that keep popping up as we go through the meeting. Please wait two seconds while I write this final point down. [*Laughter*.]

Graeme Dey: You could also note that it is "minister" and not "cabinet secretary".

Jim Fairlie: I am sorry, minister—I did not even read your name card.

I return to the one of the first points that the convener raised, which was from a question that a member of the public had asked. If someone has had Covid in the past, why does that not show up and allow them to travel? Are you scientifically confident that having had Covid gives a person the same level of immunity as vaccination? When someone has had Covid, for how long are they immune?

Professor Leitch: We do not know—nobody knows. We do not know whether immunity through vaccination and natural immunity are the same, but we think that that is probably not the case. We think that immunity from vaccination is probably longer lasting, which is why everybody who has had Covid should get vaccinated—having had Covid is not an excuse for not getting vaccinated.

Immunity is enormously complex. It is not the case that we get one individual chemical that protects us for X amount of time. It is a massively complicated biological mechanism with multiple cells and proteins that protect us at various levels. In addition, immunity varies according to the individual. A young person is likely to have a better immune response than someone who is 90, but that is not always the case; some 90-year-olds have a very good immune response. One of the challenges is that blood tests do not give a response in marks out of 10: they give only a yes or a no on whether there is immunity.

People who have had the disease are unlikely to catch it again soon. From the science, we have been saying that that means about 90 days, so a person would not need to test themselves again for 90 days because they are more likely than other people to test positive. However, people do get the disease twice. It is usually less severe the second time and it usually goes away more quickly, but it can still happen. That is why people should restart testing after 90 days.

Natural immunity is good and people who have had Covid are somewhat protected, but they should still get vaccinated.

Jim Fairlie: People who have had Covid might have some natural immunity, but they do not have immunity for the time that vaccination provides. I am emphasising the point that you made: despite a person's having had Covid, it is essential that they get vaccinated to help to protect society as a whole.

Professor Leitch: That is correct. We must remember that the vaccine is not the virus, so superimposing the vaccine on top of the virus is risk free. There is no reason why someone who has had the disease cannot be vaccinated.

Jim Fairlie: I am pressing you on the issue because numerous constituents have said to me that they have had the virus and do not want to get vaccinated, because it is a disgrace and an impingement on their human rights. That is why I needed the scientific assessment for why we ask people who have had Covid to get vaccinated.

Professor Leitch: That is their choice—although, of course, I argue that it is the wrong choice for them and their families.

Graeme Dey: People who have been vaccinated who think that they have had Covid should still be taking lateral flow tests.

Jim Fairlie: I will return to Alex Rowley's point. We are hearing concerns about older people not getting their booster jags in the same way as they were vaccinated before. Previously, the vaccination programme went out to the community, but that is not happening now. I do not know whether you can answer on a local basis with regard to Perthshire South and Kinross-shire, where we have people having to travel what they consider to be huge distances to get a booster jag, whereas previously they went to their GP surgery or wherever. I assume that the answer will be the same, which is that the booster programme is a much bigger programme that is to be delivered in a shorter time, so we are doing the best we can.

Professor Leitch: That is correct. Those are the fundamentals,. We apologise for the compromise that has to be made. Everybody wants the booster yesterday, on their doorstep, but we have to compromise somewhere in order to get the booster to people as fast as we can, as close to them as we can. That means, unfortunately, that some people will have to travel further that they did previously.

I was on a site visit to Orkney and Shetland 10 days ago. Orkney was vaccinating all its 12 to 15-year-olds in one weekend—that was the compromise that it had made. All 881 of those youngsters were going in a oner to the hospital to be vaccinated, if they wanted it. That meant that Orkney got huge numbers done, but the logistics of travel were enormously complex for some of the families. After that weekend, the programme would go out and pick up people who had changed their minds and so on. There is a compromise between speed and distance.

Jim Fairlie: I have a very quick question for Graeme Dey, and then I will have to come back to you, Professor Leitch. I apologise. Can the Scottish Government force GPs to take all face-to-face appointments?

Professor Leitch: No.

Graeme Dey: No.

Jim Fairlie: That is all that I need to know.

Professor Leitch: Also, it would not be right to force GPs to do all face-to-face appointments. For example, my dad does not want to go in every time; sometimes he likes a phone conversation.

Jim Fairlie: That is the answer that I needed. It was either yes or no, so I am happy with that answer.

We have talked at great length about vaccination resistance, and we will come to the vaccination passport process. I heard you speaking on the radio—I think that it was yesterday morning—about there still being resistance to vaccination in the 18 to 29-year-old age group. Is there still resistance among ethnic minorities and among any other age groups that we should know about?

Professor Leitch: The biggest worry for us, as clinical advisers, is that "invincible" age group who think that they are special. The most recent data suggests that pretty much everybody over 50 is done, with just a few catch-ups to be done. The rate falls a little in the over-40s, but not significantly.

The last time I looked at the rate for 18 to 29-year-olds, it was at about 75 to 80 per cent. I will look at it again and get back to the committee, but it looks as though there is a stubborn 20 per cent, because the rate has not moved much over time. We have done quite a lot of outreach to that community. We hope that vaccination passports are part of the solution for that cohort. We have done a lot of advertising that is invisible to the likes of over-50s such as us, and we have sent a lot of mobile units to further education colleges, workplaces and universities, including at freshers weeks, during which we did a lot of mop-up vaccination.

However, vaccination remains a personal choice; there is only so much that we can do when people do not come forward. We would be grateful for anything that MSPs could do to encourage youngsters in that age group—who will, we must remember, not get severe disease, in the main—to come forward to protect themselves and others.

Graeme Dey: Jason made a point about the role of MSPs. We rely on colleagues in Parliament to assist us in getting messages across, whether it is in that sphere or in one of my areas of responsibility. An example from public transport is that as we have opened up and lifted restrictions on ferries, many outbreaks have affected ferry crews. Any assistance that MSPs on the committee could provide to reinforce messages about the simple measures that people can take to help us get through this third wave—as Jason refers to it—would be incredibly helpful.

Professor Leitch: Seventy-eight per cent of 18 to 29-year-olds have had a first dose, and 67 per cent have had a second dose. That second figure will catch up, because some of them are not ready for their second dose yet.

Jim Fairlie: Okay.

Professor Leitch: Let us say that there is a stubborn 20 per cent that we would like to get to.

Jim Fairlie: You need to get more from that 20 per cent.

Professor Leitch: We are trying.

Jim Fairlie: I have one last quick question for the minister on face masks being worn on public transport. Huge numbers of people on the local bus service in my constituency are not wearing face masks. What can we do to enforce it?

Graeme Dey: It would surprise me if there were "Huge numbers"—

Jim Fairlie: That is what I hear anecdotally from people who are coming to me.

Graeme Dey: Colleagues will have different experiences; my experience on buses has been more positive.

We are engaged directly with bus service providers. I pay tribute to the work that they have done to support us. There will be examples of people not wearing masks; if you have examples from a particular bus route, please bring them to me.

I had a meeting with the Confederation of Passenger Transport two days ago. It is doing more and more to encourage mask wearing, but there is a limit to what it can do. There have been unfortunate instances of bus drivers being verbally abused when a person has got on a bus and the driver has asked them to put a mask on. However, some people sitting on a bus without a mask might be medically exempt, which will not be obvious. If MSPs have specific examples, please bring them to me and we will engage with the relevant bus provider.

Jim Fairlie: Thank you.

Brian Whittle (South Scotland) (Con): Constituents have raised a couple of points with me, one of which relates to the warning period for a change in a country's status as regards travel. Sometimes, the status of a country that people have travelled to changes while they are there so they face a mad scramble to get home again. Is a change of timescale being considered so that people are not caught out in that way?

Graeme Dey: I recognise that description, but it is largely a thing of the past. Only a small number of countries are captured by the red list. All four UK nations have become increasingly aware of the need to avoid such situations. The issue that you describe is one that arose previously, but I am not sure that it is as relevant now, when only a small number of countries are captured by the red list.

If I was not here, I would be taking part in a Covid operations committee meeting with the other UK nations to discuss what to do next. There is regular dialogue on such matters. As part of that, there is recognition of the need to engage with travellers to minimise the difficulties that were experienced previously.

Brian Whittle: An issue that I have been on about for a while is that of the vaccination status of other countries and how vaccine proliferation is measured in other countries. How can we be confident that the data that comes out of other countries is robust? I am always wary of making comparisons with other countries, because the way in which they measure their vaccination status varies hugely across the world. How can we be confident that the data that we get from other countries in relation to the travel zone is robust?

Graeme Dey: I can offer a political perspective, based on the discussions that I have been involved in. We are given extensive clinical advice and, when there are degrees of doubt, that is explained to the politicians before we make such decisions. Progress—if you want to call it that—has been made on the number of vaccines that are now deemed to be acceptable, although there are still a couple that do not pass muster, from our perspective.

From a political judgment point of view, I have felt more comfortable because of the explanations provided by our clinical advisers, who of course draw on expertise from across the globe.

Professor Leitch: You are right to say that making such comparisons is a challenge, especially because we are trying to do it globally; we are not making comparisons only with European countries or with America. COP has brought that into blinding light for us.

We proceed in two different ways. We recognise vaccines and we recognise vaccination programmes in specific countries. That includes those vaccination programmes going through a rigorous exercise across the whole of the UK. We started by recognising the European and the US vaccination programmes, which are as robust as ours. There is another layer, which involves saying, "You have to have had these vaccines." There are three or four categories of vaccine, from those that are recognised by the UK, through those that are recognised in Europe and by WHO, to those that are not recognised at all.

At that point, choices must be made. We give the advice and the politicians across the UK must make choices about which vaccines to accept.

Brian Whittle: Do you accept that it is inherently dangerous—I am reluctant to use that word—to compare what we are doing with what is happening around the world, when such a wide variety of approaches are taken to measuring, for example, the number of people who, tragically, have died from the disease?

Professor Leitch: That is a separate problem. That is not a vaccine recognition problem, but a problem of whether we can compare Covid data globally, which is much more difficult.

If we were to look at the UK, the headline would be, "Large numbers of cases," but we have done more testing than anyone else. That is a good thing, because it enables us to fight the disease by identifying and treating it, but it is not how other countries have chosen to deal with the situation.

If you just look at the raw number of cases in country A versus those in the UK, you might think that country A has got away with the pandemic in a completely different way than the UK. The reality is that country A has not found the disease, although it still has it. We therefore must be cautious and go to trusted sources such as the WHO, which has tried to get beneath the data to work out what the reality is.

We will not know what the pandemic has genuinely done around the world for a long time, until we can look back and see what happened.

11:15

Brian Whittle: Are you saying that we MSPs must temper the way we talk to one another in the chamber?

Professor Leitch: You should talk to one another however you choose. You should temper the way in which you speak to me—that would be a different problem. [*Laughter*.]

Brian Whittle: Another issue that NHS professionals have raised with me is the pressure on the NHS caused by absenteeism because of people getting regularly pinged by test and protect. I have heard about cases of neonatal units where there are supposed to be 12 people on duty, but there are only three. Such situations are inherently dangerous and relate to the impact of non-Covid-related incidents. Where are we with that? How we are measuring the situation and keeping on top of it?

Professor Leitch: I have looked briefly, but I do not have the actual absence data. We can get it for you.

The last time I saw the data, which was probably last week, it was average. However, you highlight the problem with looking at average absentee data. Average absentee data is data across 183,000 employees in the NHS system alone. Underneath that, there are very specific pinch points, such as paediatric intensive care, or a dental practice that only has four people in it. In such cases, the situation is more challenging.

Nothing on my radar is saying that there is a particular workforce challenge about a specific unit, other than the general workforce challenge that we have everywhere. Any such issues would get raised through the health board up the way, and would eventually reach us if there was a real problem.

We have mutual aid in place for really fragile services, such as paediatric intensive care. We have two paediatric intensive care units in the country, and they can share staff and cots if they have to. Therefore, there are mechanisms to manage the situation.

I do not know of any particular challenges relating to staff self-isolation. The self-isolation rules have changed relatively recently to allow a bit more flexibility for health and care workers who are vaccinated.

Brian Whittle: I am not looking at the position across the country; I am talking only about my area, where it seems to be an issue.

Finally, on Alex Rowley's point about access to GPs, there is variation across the country in that regard. I have tried to get an elderly relative an appointment with their GP. They still have not seen their GP; they ended up in hospital. However, when my parents phone up their GP, it is easy for them to get an appointment. There is a wide variation in access to GPs across the country.

I know that we cannot force GPs to do things that they do not want to do, but given the huge variation across the country, the situation should be continually monitored.

Graeme Dey: As transport minister, I am not an expert on the matter, but it might be worth my while to ask health colleagues to write to the committee on that point, because a couple of MSPs have raised it. I will ask the relevant health minister or their officials to engage with the committee.

The Convener: That is appreciated, thank you.

John Mason (Glasgow Shettleston) (SNP): We have already covered quite a lot of ground. I note that in the amendment number 3 regulations, we are recognising mixed-dose vaccinations, both from this country and overseas. If I remember correctly, previously we were not mixing vaccines, and there was a bit of uncertainty about doing so. There was a suggestion that it might give greater protection, although there might be more side effects. Will you give us an update on that?

Professor Leitch: The position is not definitive. Early trials suggest that the vaccines are, in the main, behaving roughly the same, and that mixing first, second and third doses of the vaccine does not make much difference. That is not much of a scientific sentence but, in the main, for this disease a vaccine is a vaccine, and they are all roughly in the same place. That is why, for the booster dose, we tend to use the one that we have available. We have Pfizer, so most people are getting Pfizer for their booster, because the Joint

Committee on Vaccination and Immunisation said to use a messenger RNA vaccine.

If you had to have a typhoid vaccine because you were going to India, you would not check the manufacturer. That is where we are headed. We had to do the science in real time on television, so people knew which company came first and which came second. However, the issue of choosing your vaccine is neither here nor there, unless someone has a specific indication that means they cannot have a certain vaccine. That goes for some young people and some people with allergies, but that is a different question. In the main, the majority of people can have whatever vaccine is available.

John Mason: Following on from a question that was asked earlier—I cannot remember who asked it—does the length of protection vary for vaccines? I think that, at one point, there were figures that suggested that there was some variation.

Professor Leitch: The earlier data suggested that, but the medium-term data that is being gathered as more people get the vaccine suggests that it is all coming together. That is exactly what we would expect to happen. There will be a normal distribution. It is important to remember that whether someone gets the disease is yes or no, not marks out of 10, and an individual does not know whether they will get the disease or not. The length of protection from the vaccine will be nine, 10 or 11 months, and in some people it will be a shorter period and in some, it will be longer.

We are giving people boosters because we are not sure what happens in the end. Chile and Israel have seen vaccine waning. Israel had a three-week gap between their first and second doses—you will remember the controversy around three weeks versus eight to 12 weeks. Because of that waning, they have implemented a booster programme, which started earlier than ours. We are not seeing significant vaccine waning across the UK, so our booster dose is being given in anticipation of vaccines beginning to wear off.

John Mason: We have not mentioned vaccine certificates much today. Is there any evidence so far that they are encouraging people to get jags?

Professor Leitch: I simply do not know, and it is difficult to unpick any such trend from the figures for a general increase. I could argue that the situation with teenagers has gone really well, because we have reached a figure of 75 per cent of 16 and 17-year-olds. That is amazing. I did not think that we would get anywhere near that in that age group. However, as we discussed earlier, I am still worried about the stubborn 20 per cent of 18 to 29-year-olds. We have not pushed that age group to 95 per cent, which is where I hoped to get to.

The Convener: We are running a bit short of time, but Professor Leitch will be back next week, so we can ask him more general questions then.

Item 4 on the agenda is consideration of the motions on the affirmative instruments that we considered under the previous agenda item. The Delegated Powers and Law Reform Committee have yet to consider the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 5) Regulations 2021 (SSI 2021/359), so we will take the relevant motion at our meeting on 18 November.

I see that the minister does not wish to make any further comment on the instruments. If members are content for the motions to be moved en bloc, I invite the cabinet secretary to move the motions.

Motions moved,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Regulations 2021 (SSI 2021/322) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment Regulations 2021 (SSI 2021/328) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/343) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 3) Regulations 2021 (SSI 2021/350) be approved.

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 4) Regulations 2021 (SSI 2021/357) be approved.—[*Graeme Dey*]

Motions agreed to.

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

That concludes our consideration of this agenda item and our time with the minister. I thank the minister and his supporting officials for their attendance this morning. The committee's next meeting will be on 4 November, when we will take evidence from the Deputy First Minister and Cabinet Secretary for Covid Recovery.

That concludes the public part of our meeting this morning. We now move into private session.

11:24

Meeting continued in private until 11:37.

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