OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 23 March 2023

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 23 March 2023

CONTENTS

Col.

LONG COVID INQUIRY 1

COVID-19 RECOVERY COMMITTEE

7th Meeting 2023, 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:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Christopher Doyle (Scottish Government)
Dr John Harden (Scottish Government)
Ashleigh Simpson (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 23 March 2023

[The Convener opened the meeting at 09:41]

Long Covid Inquiry

The Convener (Siobhian Brown): Good morning and welcome to the seventh meeting in 2023 of the Covid-19 Recovery Committee. We have received apologies from Alex Rowley, and I welcome to the meeting Jackie Baillie as his substitute.

First, I just want to take a moment to recognise and reflect on the third anniversary of our going into lockdown and to send our condolences to all those people who have lost a loved one or a family member to Covid-19.

This morning, we will conclude our evidence taking for our long Covid inquiry. I welcome to the meeting Humza Yousaf, the Cabinet Secretary for Health and Social Care, and from the Scottish Government, John Harden, deputy national clinical director; Ashleigh Simpson, team leader, planning and quality division; and Christopher Doyle, senior policy manager, clinical priorities unit.

Would you like to make some short opening remarks, cabinet secretary?

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Thank you very much, convener, and good morning to you and to committee members.

I want to start exactly as you did, convener, and offer my condolences to people who lost loved ones over the course of the pandemic and who are continuing to do so. I would also reflect, as we will in the course of this conversation, that many who first contracted Covid suffer to this day from its long-term debilitating effects.

I am grateful for the opportunity to appear before the committee to discuss the impacts of long Covid and to provide information on the steps that we are taking to support the health and wellbeing of people with the condition. As committee members know, long Covid is a term that encapsulates a wide range of more than 200 different symptoms, which vary highly between people.

At present, the underlying causes are poorly understood. What is well understood, however, is that for the adults, children and young people most severely affected, the symptoms are having a significant impact on everything from their physical and mental health through to their education and employment. Indeed, I have heard as much myself in my meetings with people with long Covid and from those in our national health service who support them. For those who are severely affected, life can be extremely challenging.

Around the world, science has begun the work of trying to find not just an explanation but treatments for long Covid. That science is still in its early stages, and proven, safe, evidence-based treatments are still in their infancy. Scotland is contributing to that worldwide research effort and, in the meantime, we are taking steps to test new ways to support people. We know that, as we evolve our understanding of the disease, the current lack of effective treatments can, understandably, contribute to distress, and we understand the need for supportive care that recognises the challenges faced by people who are living with those symptoms.

At the moment, the clinical guidance recommends the provision of treatment for people's specific symptoms, where possible, or a rehabilitative approach to help people manage the impacts of their symptoms on their day-to-day lives. That care and that support are being provided through the full range of services delivered across our NHS. People can access general practitioner assessment in a setting close to their home, and GPs can then make referrals to community rehabilitation services or secondary care pathways such as respiratory care or cardiology, where appropriate. Those individual services are best placed to investigate and support people who have as a result of long Covid symptoms that might require support.

09:45

That said, I know that people's experiences of accessing and navigating support can be challenging. There is certainly room for improvement—there will be no challenge to that premise from me. That is why we are committed to investing £10 million in a long Covid support fund and have made an initial £3 million available from the fund this year. Rather than mandate one specific model, we are supporting NHS boards to innovate and plan based on local needs and infrastructure. The long Covid support fund is targeted additional resource for NHS boards to increase the capacity of existing services, to develop them into more clearly defined pathways and to provide a more co-ordinated experience for those accessing support. We have heard time and again from long Covid sufferers that that is what is needed. The approaches being tested include looking at ways of achieving those outcomes through having a single point of access for assessment and co-ordinated support from

services, including physiotherapy and occupational therapy.

Along with our support for the initiatives that are under way in boards, the Scottish Government has delivered a clinical guideline implementation support note to help GPs effectively assess and refer people with long Covid. We have a dedicated microsite on NHS Inform that contains key information and sources of support for people with long Covid; we have launched a marketing campaign to increase awareness of the condition; and we have allocated funding of £2.5 million for nine Scottish-led research projects to better understand it. As the committee knows, we have also established a national strategic network, which brings together people with lived experience, clinical experts and those working on local service responses.

Long Covid is undoubtedly a considerable challenge. There is still much to do and learn, and there are improvements to be made, but we have an opportunity for our healthcare system to adapt and learn based on the best evidence available.

I very much welcome the committee's inquiry on the issue and the opportunity to discuss it and to take questions from members.

The Convener: Thank you, cabinet secretary. I also want to thank you for yesterday's update on the reallocation of unspent funds to 10 new projects that are being led by the third sector.

During the inquiry, the committee has been keen to hear from people with lived experience of long Covid; we have taken evidence from a lot of groups of people suffering from the condition and have received more than 500 responses from the general public to our call for views. I will share with you a comment from Jane Ormerod from Long Covid Scotland, who said:

> "What the Government says is happening and the reality for people with lived experience do not match up. I agree that different things are happening in different health boards and that consistency is an issue. I know that everywhere is different and that the geography is different, but there needs to be overall consistency and shared principles of what that should look like in each health board".—[*Official Report*, *COVID-19 Recovery Committee*, 9 February 2023; c 13.]

As we have gone through this inquiry, it has become evident to the committee that all the health boards are doing different things. I appreciate that some boards have experienced delays in recruiting to posts in order to implement pathways for taking care of people with long Covid, but are there any plans to develop guidance for NHS boards on specific pathways for people with the condition?

Humza Yousaf: I thank you for your question and, indeed, Jane Ormerod for her comment. She, too, has been at those meetings at which I have met people suffering from the effects of long Covid.

In your question, you have expressed the purpose of the national strategic network, in which people who provide local services, those with lived experience and our clinical experts are making contributions to get the level of consistency that we require. I am certain that the committee will have pored over the detail of the funding allocation for each NHS board. From that, you will see that many health boards are looking to have a single point of access and to develop the pathways better. It is clear that they are looking at where such an approach is working well—NHS Lanarkshire provides a good model in that respect—and are trying to get that level of consistency, but Jane Ormerod is not wrong: there is a lack of consistency and a difficulty in accessing pathways.

That is why the implementation support note is so important. It ensures that when somebody goes to their GP—who will be the first port of call for the vast majority of people, if not everyone—the GP will have a flowchart, telling them where the referral pathways should be and what other support services will be available. Work on that is under way; indeed, it is one of the key areas that the funding will support.

I take Jane Ormerod's point entirely. We are trying to strike a balance here; we are looking for national consistency, as that is important, but that does not mean taking a one-model-fits-all approach. I can highlight a great example from NHS Highland. We all know about the geography of the Highlands and how disparate the population is; NHS Highland has a good virtual model that is working well, and which it is developing further, but clearly, the model has been developed for that health board and is suitable to local needs. There will not be a blanket approach, but Jane Ormerod is correct to say that there must be consistency in access to pathways.

The Convener: That was helpful.

What actions has the strategic network taken to improve the consistency of care for people across Scotland with long Covid, and what oversight of the network does the Scottish Government have?

Humza Yousaf: Obviously, we are involved in the strategic network, and I might ask some of my officials to come in and add some detail. The model is one that is used for trauma networks; it is well known and well tested, and it has had some very positive outcomes.

In essence, the network brings together key partners—clinical experts, those who are delivering local services and those with lived experience. We can provide more detail on some

of the action that has been taken with health boards to create referral pathways, particularly rehabilitative pathways, which we know are working well in some health board areas but which, in others, clearly need more work. As I have said, one of the core issues reported by those in primary care is that they do not have information on where to refer people, and that is why the development of the implementation support note has been really important. A load of key actions has come out of the national strategic network, with more actions to come, but its value lies in bringing those three key partners together to improve services for those who have long Covid.

I do not know whether any of my colleagues want to come in on the topic of strategic networks. Chris Doyle is probably best placed to do so, given his team's closer involvement.

Christopher Doyle (Scottish Government): I agree that the strategic network is a key tool for us in supporting improvement and consistency at a national level. It brings boards together to share information on and learning about the models of care that they are developing and implementing, and it will be key to helping us learn and evaluate the models of care that boards are delivering and to ensuring that we learn and capture that information.

I would add that the network has a clinical and subject matter expert group that is collating information on current pathways of care for people who have long Covid, and the group has indicated that it will support the development of standardised guidance in addition to that work, if appropriate.

The Convener: When we spoke to many suffering from long Covid, we found that one of the issues that they face is the prevalence of Covid that is still in the community—indeed, it is a major concern. I note that the Scottish Government is currently undertaking the autumn and winter booster programme, but as of 12 March, only just over 2 million people had taken up the winter booster, whereas 4.5 million got the first booster and just over 4.3 million got the second. There seems to be apathy among the general public about taking up the boosters, and that has grown over time. Does the Scottish Government still believe that it is important that people continue to take up what the vaccine programme offers? If so, what public health messaging is being put out there to encourage people with regard to the importance of having the booster?

Humza Yousaf: Thanks for that question. You are absolutely right to ask about this. We were always concerned that apathy and vaccine fatigue might kick in among certain cohorts, but it is really important to note that, as the data shows, there has not been such fatigue among others. For example, there is still a good level of uptake from those in our older population and those in residence in care homes. That said, we have seen some drop-off in the 50 to 64 age group, for example.

We had some concerns about the uptake in relation to social care staff, so we put a lot of effort into working with the likes of Scottish Care and others to see whether we could boost those numbers. It is worth saying that our uptake rates for autumn and winter vaccines are still the highest in the United Kingdom, which is a positive, and we continue to work on a four-nations basis to see what we can do in a co-ordinated way.

As you will know, we also had in the past year the Covid sense campaign, which reminded people of good behaviours and what to do if they had Covid symptoms—it highlighted good hygiene, ventilation and so on—and it will continue to make the case for vaccine uptake. Indeed, it will be an important piece of work for us, given that the immediate impacts of Covid are not so evident, now that they are not in our news 24/7. Ultimately, if we can reduce the numbers of people suffering from Covid, we will hopefully reduce the numbers of people impacted by long Covid.

That said, I could not agree more with the premise of your question, which is that we should be doing everything in our gift to increase vaccination rates.

The Convener: I move to my last question. I know that recruitment is a problem in the NHS at the moment. How can health boards be supported to recruit for long Covid posts, and to what extent would recurrent funding address the recruitment issues that health boards have highlighted?

Humza Yousaf: That is a really good question. Recruitment undoubtedly is, and continues to be, a challenge. What we are doing is making it clear to health boards that the £10 million funding, which comes on top of their core allocation, will be available over the next few years. We know that there are some issues with recruitment, but we are working—and will continue to work—with the boards to see what more we can do about those challenges.

The challenges will be different from board to board; our colleagues in NHS Grampian, for example, will face different challenges from those in NHS Greater Glasgow and Clyde. The recruitment challenges are one of the reasons for the full £3 million not being spent this year, but I have made it very clear to health boards that the £10 million will still be available over the next few years.

The Convener: Thank you very much.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, cabinet secretary; I welcome your colleagues, too.

I want to follow on from the convener's line of questioning. During the inquiry, we have heard a lot from long Covid sufferers about their issues in trying to access services. I want to read you an email that we received a couple of weeks ago from a long Covid sufferer in Aberdeenshire—I do not have permission to give his name—to give you a flavour of some of the feedback that we have had. Recounting his experience, that individual said:

"I've just been forced to make a private GP appointment ... due to the complete lack of support from the NHS. Actually, it's worse than that as my current GP surgery is utterly dismissive."

He has a long Covid diagnosis. He went on to say:

"In December, I was forced to take a day off work, contacted the surgery"

and

"The GP told me: 'There's nothing to be done for long Covid.' ... 'Current NICE guidelines state we are not to prescribe pain relief for chronic pain'"

and

"'You have to take responsibility and self manage'."

It is clear that it is not acceptable that individuals who have a long Covid diagnosis are getting that response from their GPs, is it not?

Humza Yousaf: I agree. I wonder whether that is the same person from Aberdeenshire whom I met—I will not say their name. I heard about a very similar experience from a young person in Aberdeenshire who felt that their GP was dismissive. I have heard that experience from people not just in Aberdeenshire but in many other parts of the country.

That is why not only the National Institute for Health and Care Excellence guideline but the implementation support note, on which we can give the committee further detail in writing through the convener, if it wants that, give a level of detail on the referral pathways that are available, and why we have put so much work, through the strategic network, into the education tools that are available for GPs.

I highlight the written evidence that the Royal College of General Practitioners gave to the committee, in which it stated that it believes that primary care and GPs are the first port of call and are "best placed" to give a holistic assessment before onward referral. I agree with it.

I would be more than happy to provide more detail on that in writing, but that is why so much work has gone into assisting our GP colleagues, who are facing a number of challenges from the pandemic around where those referral pathways are.

10:00

We have the implementation support note and an education strategy to raise awareness of long Covid. NHS Education for Scotland also has its learning platform, and I suspect that members will know that it contains a video and webinar content on long Covid. There is a lot in that space, and we are working closely with our primary care and GP colleagues to make sure that they know about the pathways that are available.

Murdo Fraser: I appreciate that that is work in progress. We have heard that over a long period of time, but the feedback that we keep getting from people is that their experience on the ground is still lacking.

That individual said that he had to go private. That has been a consistent theme in what we have heard from long Covid sufferers. People have had to go private to try to access a GP who has expertise in the area. That is fine for those who can afford it, but many people cannot afford it. Have we therefore not created a two-tier system? Is that not unacceptable?

Humza Yousaf: I do not want a two-tier system. We have heard about that in other areas of the health service where, for example, people have waited for elective care. I will not rehearse the reasons why we are in the position that we are in and why people have felt that they have had to go private. That is not what I want. As the Cabinet Secretary for Health and Social Care, I want everybody to be able to access NHS services.

I go back to what I said in my opening remarks. The science around the treatment and the symptoms of long Covid is still in its infancy—I think that everybody around the table would accept that. There is no one treatment that we can give, although a number of treatments can help with some of the symptoms. However, I have heard far too often from long Covid sufferers that, when they go to primary care or their GP, they are passed from pillar to post and there is no single point of access. I think that I can safely say that the majority of the health boards—or a significant number of them—are using the funding that we have given to them to create a single point of access so that an individual is not passed from pillar to post.

To answer your question, of course I do not want people to feel that their only option is to go private. That is why we need to improve the services that we have.

Murdo Fraser: You have talked about a single point of access. That is a very important point, and

we have heard about that in a lot of the evidence that we have taken. We have also heard that long Covid sufferers would like long Covid clinics to be established in Scotland to provide a specific service. What is your thinking on dedicated long Covid clinics being established in Scotland, as happens in other parts of the UK?

Humza Yousaf: We have looked at other long Covid clinic models around the UK, such as the Hertfordshire model, which Dr Sandesh Gulhane has mentioned previously. I go back to the Scottish intercollegiate guidelines network and NICE guidelines on long Covid, which say that one model would not fit all areas. I think that we all accept that.

I agree strongly with the RCGP's written evidence to the committee on that. I will quote it directly. It says that long Covid

"often requires generalists skills to treat, but most can be fully managed in primary care, and the GP is best placed to provide this holistic approach."

It goes on to say:

"there is an increased risk that patients presenting with Long Covid symptoms may have instead another cardiac or respiratory condition which may have similar or even identical symptoms. Patients need a GP assessment and investigation"—

this is the important part—

"rather than being funnelled inappropriately into a clinic that is designed for one condition, and then require further investigation and alternative management."

I have never been opposed in principle to long Covid clinics—I have said that from day 1. That is why I have asked my team to look at the Hertfordshire model, for example. In effect, they try to cut out the middle person. We have GPs and, if they have the appropriate referral pathways through the implementation support note that take people directly to a Covid rehabilitation service in, for example, Lanarkshire—that is the example that I keep using—that is a better model than a GP having to refer someone to a long Covid clinic that would then have to refer them on to another pathway. I am not opposed to long Covid clinics in principle; I am trying to allow local health boards to design services to meet their local need.

Murdo Fraser: If I were a long Covid sufferer in front of you, I would say that it is fine that you are talking about developing the pathways and that you recognise that there are issues, but the key question is: when will we get to a state in which we have the services that people need?

Humza Yousaf: That is a very fair question. Some areas have that service. In the Highland service, which I have talked about, there have been 100 referrals and, in Lanarkshire, well over 500 referrals have been made. We lack a single point of access and the connect between the primary care and secondary care services. That is exactly what the funding is intended to address.

I have every faith that more and more health boards will develop those services much more consistently. Some are already doing that. Some are using the funding and giving us timescales for when the pathways will be more fully developed. However, Murdo Fraser has hit the nail on the head. That is the number 1 issue that comes up from long Covid sufferers time and again. They say that it all sounds good, but they ask whether the approach is consistently working across the country. The answer to that is not yet. That is what we are working on.

Murdo Fraser: Maybe that will be a job for your successor as health secretary if you are no longer in that role. Who knows?

Humza Yousaf: You are the second person to sack me in a few weeks.

Murdo Fraser: I have a follow-up question on a slightly different topic. Yesterday, you wrote to the committee with a list of funding that had been allocated in the current financial year. Various funding streams were announced for third sector organisations, which is welcome. Is that £334,000 money that was unspent in this year's budget?

Humza Yousaf: Yes, in short. Initially, £3 million was allocated, and there was an underspend of, I think, £1.1 million of that. We then went out to third sector organisations because health boards could not spend that money because of recruitment challenges. We have given a clear and absolute guarantee that the profile of the £10 million of funding might well change and might not be just over £3 million per year.

To answer your question in short, that money is part of that underspend.

Murdo Fraser: The funds that have been allocated are within this financial year's budget.

Humza Yousaf: Yes.

Murdo Fraser: Do the organisations need to spend that money by the end of the financial year or can they roll it over?

Humza Yousaf: I think that it has to be spent in this financial year. Certainly, they have to begin the work on spending it in this financial year. Forgive me: I can get you absolute clarity on that post the committee meeting. In essence, the organisations are building on projects that they already have under way.

Murdo Fraser: The end of the financial year is only two weeks away. That does not give them very long to spend the money.

Humza Yousaf: No. The money was distributed before the letter was sent to you.

Murdo Fraser: Right. How long before?

Humza Yousaf: I will need to check. I am not sure whether my colleagues know exactly when that money was given to the third sector organisations. However, we worked with those organisations, made it clear that the money was coming as part of the money that health boards could not spend, and asked whether they were confident that they would be able to meet the criteria for it. That is why, as you will see, the amounts are, in some cases, relatively small and, in some cases, larger. The organisations are building on existing programmes. However, the fundamental point is that we have given a guarantee to health boards and others that the £10 million will be available over the next few years.

Jackie Baillie (Dumbarton) (Lab): I welcome your comments about improving services, cabinet secretary. I will pick up where you left off. You said that there was a £1.1 million underspend, but the allocation that I have in the table in front of me is for £334,000. Where is the rest of the money being spent?

Humza Yousaf: It will be reprofiled over the next few years.

Jackie Baillie: Okay. So you are carrying that bit forward. That is fine.

Less than £3 million was allocated to health boards as part of the £10 million over three years and you will recall that, at the point that you made the allocation, 74,000 people were affected by long Covid. Of course, now, unfortunately, 175,000 people are affected. Do you intend to increase the overall resource available?

Humza Yousaf: That is a fair question to ask. Of course I would look to see where we can provide even more support. I make the point, which I know is well understood by colleagues around the table, that the long Covid fund is on top of the £18 billion in this financial year and £19 billion in the next financial year that we are giving to the NHS and social care, a chunk of which is given to our health boards. It is worth saying that our front-line spend per head is higher in Scotland than it is in other parts of the UK. It is £323 per person higher than it is in England, for example.

I keep going back to the Lanarkshire model because I have seen it first hand, and I have spoken to some people who have benefited from that service. When that rehabilitation service was up and running, people did not wait for the allocation from the £10 million long Covid fund; they used their health board allocation to create that team—to recruit and hire those multidisciplinary team members who are providing that support to long Covid sufferers. I hope that that gives you some reassurance.

Jackie Baillie: It does indeed, but that has not been the case in every health board across Scotland—

Humza Yousaf: Agreed.

Jackie Baillie: —so we have a postcode lottery.

By May 2022, NHS England had allocated £224 million to support assessment and treatment of long Covid, and £90 million was for 2022-23 alone. Our share of that in Barnett consequentials would produce £21.7 million in Scotland. I therefore ask the cabinet secretary where that money has gone and whether he will use some of it to enhance the Covid services that are currently a postcode lottery on the ground.

For the benefit of your officials, those statistics are from the Scottish Parliament information centre and the House of Commons library.

Humza Yousaf: Yes, I accept that. Every single one of the health and social care consequentials that come our way is spent on health and social care. That has been a commitment of this Government for a number of years now. I will look to see where we can possibly increase our funding for long Covid specifically.

However, I go back to the point that I made to Jackie Baillie a moment ago, which is that our front-line spending for health per head is higher than it is in other parts of the UK. Yes, the long Covid support fund is important to increase and supplement some of the on-going work, but it is just that—supplementary or complementary to the funding that health boards are already spending. That is not just in Lanarkshire, which is the example that I have given, but throughout the country.

In my role, I am more than happy to explore that, and I am certain that whoever is in this role after me will look to explore whether that funding can be increased.

Jackie Baillie: I will take that as a commitment from the incoming First Minister to increase long Covid funding. Thank you so much—you have made my day.

Humza Yousaf: That is not quite what I said.

Jackie Baillie: Well, I heard that.

I want to take you on to the primary care improvement fund. In your paper entitled "Scotland's Long COVID Service", which was published in September 2021, you said:

> "Through our Primary Care Improvement Fund, we will continue to support and expand the range of professional roles in primary care that play a key role in the provision of services that can support people with long COVID."

Therefore, we all agree, but the fund was cut by £65 million in the emergency budget review. Did

that not have an impact on primary care and community-based support for long Covid services?

Humza Yousaf: We would have to do a further assessment of long Covid services to answer that, but I accept entirely the premise that you cannot reprofile money from one area to another without that having an impact, particularly given that I had to reprofile £400 million of funding within the health and social care budget. That clearly had an impact, and it would be foolish, and I would be insulting your intelligence and the intelligence of other people listening and watching, if I said that that was not the case. I know that Jackie Baillie understands that those decisions were made because our budget was so badly impacted by peak inflation. At that point, that made the health and social care budget worth about £1.2 billion less.

We also wanted to ensure that we gave a fair pay deal to our NHS workers. I know that Jackie Baillie fully supports that. To do that, we had to reprofile. That is why I was very keen to ensure that, when we set the budget for 2023-24, we put that money back into primary care. However, it is absolutely the case that, when we reprofile that amount of money, although we try to do it in a way that has a minimal impact, it will, of course, have an impact.

Jackie Baillie: You have taken me neatly to my final question, which is about health and social care staff. We know that they were on the front line of the pandemic, initially operating without adequate personal protective equipment. Those are the people who are suffering from long Covid. Their employment protection from Covid was removed, so now the staff are on half pay and some are on no pay. Some have been forced to leave their employment.

I have been contacted by a staff member from NHS Greater Glasgow and Clyde who said that its objective was simply to get her out the door and get her to quit her job. After 35 years in the NHS, she feels very angry and very let down. What can the cabinet secretary do to protect our health and social care workers who have long Covid from being dismissed by their employers?

10:15

Humza Yousaf: Obviously, those are individual employment issues. As Jackie Baillie will know, we took the approach to employment that the other nations across the UK took—Labour-run Wales, Conservative-run England and Northern Ireland—with the additional support that we could give to those who were suffering from long Covid. We extended that support beyond when the other countries in the UK decided to withdraw it.

We are talking about important employment issues. I know that various members' bills are coming up, such as Mark Griffin's member's bill on industrial injuries. There have also been calls for long Covid to be described as a disability. Under the Equality Act 2010, it is the debilitating impact of a condition rather than the condition itself that has to be prescribed. Therefore, the effects of long Covid could mean that someone has a disability that would affect their ability to get certain benefits, including social security benefits.

I will continue to look at the issue. It is a challenge. Because employment law is reserved, we have to make sure that we understand the unique impacts of long Covid and the fact that, although there are some treatments for some symptoms, there are no treatments for others. At the same time, we have to make sure that employment law is applied consistently across conditions.

Jackie Baillie: Thank you.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): Welcome to the committee, folks. I will come on to ask about paediatrics but, before I do so, I want to go back a little bit, if that is all right.

Murdo Fraser talked about GPs, and you said this yourself, cabinet secretary. If a GP does not accept that there is an issue with someone who is a long Covid sufferer, they will not have the energy to fight the system. One thing that we keep hearing from long Covid sufferers is that they are drained. If they go to a GP who dismisses them, what is the route for them to get a second opinion? Alternatively, is there a way of compelling GPs to accept that long Covid is actually a condition and that people are suffering from it?

Humza Yousaf: Ultimately, it is not for the Government, health secretaries or ministers to override clinical judgment. That has to be up to the individual clinician.

I get really upset when I hear that people have been dismissed. For me, that has echoes of the mesh survivors, whom we have all interacted with, who, in their own words, said that they were dismissed by clinicians time and time again. I am really concerned about that, which is why so much work has been done on educational tools for our front-line primary care workers—who, I suspect we all agree, do an incredible job under really difficult circumstances, especially given the effects of the pandemic—and the implementation support note.

I would be really disappointed if I was to hear of a recent example of someone being dismissed in the way that you describe. I do not know how recent Murdo Fraser's example is or the one that you have given but, because of the amount of work that we have put in, I would be upset if there

was a recent example of someone being dismissed by their GP. Dr Harden might want to come in if there is anything further to be said on that front.

We have been taking a lot of advice from GPs. For example, Dr Amy Small, who has given evidence to the committee, has attended some of the meetings that we have had on the issue.

Dr John Harden (Scottish Government): As a clinician, I am sorry that that is people's experience, and I hope that it is a minority experience, or that it is not happening now, as the cabinet secretary has just said. We have done a lot of work with the Royal College of General Practitioners and NHS Education for Scotland, and through the implementation support note, to raise awareness and education levels among healthcare providers to make sure that they have the knowledge to recognise the symptoms and signs.

I am not a GP; I am an emergency medicine consultant. However, I am a practising doctor. We recognise patterns. We listen to people's stories and look at their symptoms and signs, and we try to piece together what we think is going on in the context in which the patient is presenting. In those circumstances, we sometimes get it wrong. I hope that we get it right the majority of times but, unfortunately, we are sometimes led down a route that means that we do not jump initially to the conclusion that it is long Covid.

That is not a bad thing. It should not stop us delivering treatment for patients' symptoms, but it sometimes means that we want to exclude other potentially more sinister conditions first. With long Covid, we see such a breadth of symptoms, which cut across so many other conditions, that it is very difficult for clinicians to know whether it is long Covid. We want to avoid the danger of clinicians jumping to the conclusion of long Covid before they have excluded other aspects.

Jim Fairlie: Okay. I point out that I am talking about a tiny minority of people, and I am not entirely sure about where we are now with regard to people not getting that.

I will talk about the partnership between the third sector and the NHS. My colleague John Mason and I attended a Chest Heart & Stroke Scotland event in this committee room, and it was excellent. Is there room for you to expand that partnership more as we go forward? Clearly, the NHS is under a huge amount of pressure, and if other areas of society, such as third sector groups, are able to help, surely we would want to do that.

Humza Yousaf: The short answer to that is yes. We have already provided additional funding to Chest Heart & Stroke Scotland, but I am very keen to see what more it can do. As you know, it is working on a unique digital pathway with NHS Lothian, and NHS Lothian wants to use its allocation of the £10 million funding for that work. I am very keen to see the evaluation of that and to make sure that we do not suffer from what I often call pilotitis—if the pathway is working well, let us make sure that we get it rolled out even further. I am keen to see how that particular programme in NHS Lothian is working.

Jim Fairlie: I will move quickly on to paediatrics. In your opening remarks, you mentioned children who have long Covid, and some of the most harrowing evidence that we have listened to has come from parents of young kids who have suddenly become completely debilitated. What pathways are available in healthcare services for children with long Covid right now?

Humza Yousaf: I agree with your description that some of the most harrowing testimony has been from young children. It is worth paying particular tribute to Helen Goss, who I suspect is known by most people here for what she does with Long Covid Kids Scotland. She is a force of nature. As well as dealing with her own personal circumstances, she has helped a lot of families of children and young people who are suffering the effects of long Covid. I pay particular tribute to the work that she does. She would be the first to say that we have further work to do in that area.

To answer your question directly, for children and young people with symptoms of long Covid, assessment and initial investigation are still provided by the primary care team. Primary care clinicians can, of course, then refer them to occupational health or physiotherapy for further advice or support. I have referred a couple of times to the implementation support note that is there for GPs, which has information on the referral pathways and the other support that exists. That was developed in consultation with the Royal College of Paediatrics and Child Health. It sets out that, where self-management, for example, is not effective, and there is a significant impact on the young person or child's education or quality of life, they should be referred to general paediatric services for investigation.

The £10 million of funding that we have made available to NHS boards, which I have referenced numerous times already, is also intended to strengthen services for young people with long Covid. One example of that, which I think I mentioned in the letter that I sent to the committee, is NHS Greater Glasgow and Clyde's recruitment of additional paediatric occupational therapist support for young people, children and their families.

Finally, I will also mention the national strategic network, which I have referenced a couple of times during this session. It is progressing a

dedicated workstream that brings together clinical experts and people with lived experience to identify needs and priority actions that are specifically for children and young people.

Jim Fairlie: One of the other gaps that we have heard about relates to the transition of children and adolescents into adult services. Are you doing any work around making sure that the transition is working for young people who go from children's care into adult care?

Humza Yousaf: That is exactly why the strategic network is so important—it has those dedicated workstreams and brings them all together at the national level. Where we are trying to improve services for adults and children, we make sure that there are no gaps between services for young people who are in that transitionary phase. As you would imagine, that issue presents itself in many other parts of the health and social care system, but it has not been raised with me specifically in relation to long Covid. However, I am happy to take that issue up with Long Covid Scotland and Long Covid Kids.

Jim Fairlie: Is there a consistent offering across Scotland when it comes to educational support for children and young people with long Covid?

Humza Yousaf: Education is an area where we want to get better. I have met a number of young people who were suffering from long Covid—in fact, we had such a meeting a number of months ago just outside the Parliament. Some families told me that their school was excellent but others told me that that was not so much the case.

That is why it is important that I am having—as you can imagine—conversations with the Cabinet Secretary for Education and Skills. We are bringing in education officials, as well as fair work officials, to go back to Jackie Baillie's question about employment. We are taking a cross-Government approach to that work, but it is fair to say that it is work in progress.

Jim Fairlie: I will move on to theme 6. In my previous life as a farmer, prevention was always better than cure. We are now dealing with the effects of people having been infected with Covid, but how will we stop it continuing to circulate? The convener made the point that only just over 2 million people have taken up the booster. What more can we do? Is it a case of more messaging? How do we get over the vaccine fatigue to remind people that the disease has not gone away and that people are still suffering and dying from it?

Humza Yousaf: That is a good point, although we should still say that the Covid vaccination programme has been really successful compared with others. You are right that we can see where the uptake level is but, generally speaking, if we compare uptake with that for other vaccination programmes, we can say that we have done incredibly well. I thank the army of vaccinators that we have up and down the country for what they have done in that regard.

We need to do everything that you mentioned. It is not just about vaccination, although that is the game changer. Vaccination must be front and centre of our response to Covid and to not just reducing the number of people who contract it but lessening its effects as best we can.

There is also continued work to do on ventilation in educational and work settings. The messaging is important, too. I referred to our Covid sense campaign, which reminds people about the measures that they can take.

We need to do all those things. There is no single answer.

We are still involved in work around surveillance—we continue to be vigilant, should there be any other mutations or variants of Covid. We continue to work on a four-nations basis in that regard, and I know that the UK will continue to work internationally with global partners on that.

There is not one answer to the question; there are multiple things that we have to do. We will keep up the regular drumbeat of campaigning, as well, of course, as the next programme of vaccination, on which we continue to take the advice of the Joint Committee on Vaccination and Immunisation.

Jim Fairlie: We know that the Office for National Statistics will stop doing its surveillance but that the Scottish Environment Protection Agency will continue to do its surveillance in the waste water plants. Are you confident that that will give us enough data to know how much disease is circulating in the community?

Humza Yousaf: We are getting the balance on that. We will continue to work on a four-nations basis with the UK Government on the various surveillance measures that we have. Waste water sampling is effective. It gives us real-time data in a way that other approaches do not necessarily do, so we will continue to ensure that we have that.

It is also fair to say that we are getting to the transition phase. We had the height of the pandemic and we are now going from pandemic to endemic. As we do that, we will end up treating Covid in the way that we treat other viral infections. Surveillance will be an important part of that transitional phase, as it is for other viral infections.

Brian Whittle (South Scotland) (Con): Good morning. I will take forward the point that Jim Fairlie made about education and ask about educating our health professionals about long Covid.

GPs are supposed to have a certain amount of time for continuing professional development built into their day or week. I hark back to my time on the Health and Sport Committee when, any time that we did an investigation into any condition, we found that there was a need to educate our healthcare professionals about that condition.

That is fine in theory, but we know that GPs are under incredible pressure at the moment, so in practice CPD is probably the last thing on their list. Given that the committee has heard stories about GPs' lack of knowledge around long Covid, how can we create a health service where—if you will pardon the expression—they have the time to breathe that will allow them to take on CPD?

10:30

Humza Yousaf: That is such a good question. I have been engaging with the British Medical Association and the RCGP on that issue for quite some time. As Brian Whittle will know, before the pandemic, many GP practices would traditionally close on Friday afternoons and would have an agreement with NHS 24 that it would pick up any calls or inquiries that came in after that. That approach gave practices the flexibility to do CPD and it meant that their patients had the confidence of knowing that their calls would be picked up by someone else.

In the course of the pandemic, practices were not able to do that. I suspect that I do not need to tell Mr Whittle how much pressure NHS 24 is still under, so we have to find another model. We are working on that with the BMA and the RCGP. For me, practitioners having protected learning time for CPD is absolutely pivotal. It is important for all of them, but it is especially important in giving our trainee doctors the confidence to progress in their roles as general practitioners. We are working on that.

At the moment, because of the pressure that NHS 24 is under, practices are approaching matters in a way that suits them, as opposed to using the previous model, which involved NHS 24. For example, in a practice that I visited, which is not far from the Parliament, GPs are having to use half an hour in the morning to go through their educational or CPD material, which is not ideal. I give my commitment to the RCGP and the BMA to see what more we can do to support them in that regard.

Brian Whittle: That is helpful. I want to go on to another topic. Quite rightly, Scotland has a world-renowned reputation in medical research. The committee has heard evidence about data collection, which Scotland is also good at. Where we fall down is on deployment of the data and using it to our best advantage. The cabinet secretary and I have a shared interest in information technology. Covid, and now long Covid, have highlighted that there is an issue with how we use our data, and with the fact that our IT systems are possibly not capable of using it to our best advantage. If we strip the matter right back, should we not now look again at how different IT systems across our nation interact so that we can deploy data in the most effective way?

Humza Yousaf: Yes—Brian Whittle and I share that interest. I do not think that I am misquoting Brian Whittle when I say that he has described himself as a data geek or a data nerd. I am the same: I think that data is crucial and key to the issue. So many of the challenges that we have faced across health and social care have happened because we simply have not dismantled the barriers to sharing data effectively.

That is why I refer to our health and social care data strategy. I am certain that I offered Brian Whittle the chance to sit down with me and my team to go through it in greater detail. I hope that he will forgive me, as we have not yet had that chance. He should meet my officials. We are not necessarily trying to have one system across the NHS and social care, but to see whether we can use the cloud infrastructure to ensure that anyone in either system who has to access data can do so through a cloud-based system. Sharing of data is incredibly important.

There are eight priority areas for action in the work of the data strategy group; I will mention a couple of the key pillars. One is data access, and sharing data is also high up there. I could not agree more with Brian Whittle about data. If he would find it helpful to have such a meeting with my officials who are leading on the strategy, I would be happy to ensure that it is arranged.

Brian Whittle: I would appreciate that, cabinet secretary.

On long Covid specifically, the world-class research that we have in this country highlights the issues that we have just talked about. How do we best deploy in our communities the data that has been gathered for our healthcare professionals on what long Covid looks like and what the symptoms are? We have heard and we know that what is happening practically on the ground does not match the research that we are doing, so how do we connect them? That has to be the starting point. What work are you doing on that? As you said, the data is cloud based, so it is about gathering all that knowledge together so that we can deploy it.

Humza Yousaf: A number of research and data points are important to us. We have referenced the ONS study. The EAVE II—early pandemic evaluation and enhanced surveillance of Covid-

19—study is helpful in that regard, too. There is a variety of data sources.

I have also asked my team—we will have such discussions on a four-nations basis—to look at the international data and research that exist. I mentioned our nine research projects and I mentioned international data, but accurate local data is required. The national strategic network, which I have also referenced, has a dedicated workstream to agree outcomes, indicators, monitoring and evaluation to accelerate progress on capturing data. That will inform planning of our health service provision for people suffering from long Covid. The strategic network is trying to get consistency across the country.

I mentioned the EAVE II study, which I think you all know about. If you do not, we can provide detail on it. The initial report on prevalence of long Covid among adults in Scotland was published earlier this month; it is another helpful data source. Dr Harden is indicating that he wants to come in.

Dr Harden: On translating research into practice, the SIGN, NICE and the RCGP guideline that has been published is unique in that it is a living guideline. There is constant review of the research that is published, which is incorporated it in updates, as we go along. The guideline was fully updated last year, but the process that sits behind that is on-going and constantly looks at research as it is published. Unfortunately, none of the research that has been published has led to any significant update to the guideline as yet, but the process is on-going.

Publication of the EAVE II results has started, and a number of other studies that have been funded by the chief scientist office will give their results in the coming months. As the research comes to the fore and is published, and the data from the studies comes out, SIGN, NICE and the RCGP will review the evidence and update the guideline, which will be pushed out into the clinical space as early as possible.

Brian Whittle: Finally from me, how do we take the knowledge that we are gathering on long Covid and educate our community about what long Covid looks like? The other thing that we hear a lot is that long Covid numbers are an estimate, because many people who have symptoms that could be long Covid do not come forward. How do we furnish our communities with that knowledge so that people know to come forward?

Humza Yousaf: We have run a marketing campaign on the symptoms that people might suffer in order to direct them to NHS Inform. I refer Brian Whittle to a YouGov poll of 1,001 members of the public that came out in February, which found that 94 per cent of people had heard of long Covid and that 76 per cent of people agreed with the statement that

“Long Covid is a serious condition for those that experience it.”

There is good understanding of long Covid, although perhaps not an understanding, such as those around the committee table and long Covid sufferers have, of all the intricacies of the condition. There is acknowledgment that long Covid exists and that it can have a serious impact on people’s lives.

We will continue to do more to make sure that people know about long Covid and—which is important—the local services that are available. The YouGov poll certainly suggests to me that there is good public awareness of long Covid, at least at a high level.

John Mason (Glasgow Shettleston) (SNP): I take your point that there might be general public awareness of long Covid, but we continue to have problems in certain sectors of the community that are not engaged with health services anyway. Men in more deprived areas hardly ever engage unless there is something very seriously wrong, and vaccine uptake tends to be worse among some ethnic minorities and in poorer areas. What work are we doing—and what could we do—to engage with the people who have not been so engaged in the past?

Humza Yousaf: That is a really good question. We have learned a lot from the vaccine programme; we have had to really understand where uptake has been lower and what we can do to respond to that—for example, by putting mobile clinics in areas of higher deprivation, and in mosques, gurdwaras and temples. We have to take the learning from the vaccine programme and make sure that it goes right across the various parts of health and social care. The UK-level survey data indicated that what John Mason said is absolutely right, which is that prevalence of self-reported long Covid is greatest among people who are aged 35 to 69 years, who are female, who live in more deprived areas and who work in social care. That goes back to Jackie Baillie’s point, as well.

We know that the data exists, and I guarantee to John Mason that what we are doing in health and social care is often focused on areas where there are issues of accessibility and lower take-up. That is something that we have learned very well from the vaccination programme, so we are making sure that it is embedded right across our health and social care approaches.

John Mason: There is a lot of misinformation, which the committee looked at previously, about vaccines and vaccine damage. I do not know whether you agree, but it is my view that it would

help if we could get some simple figures out, such as the one that I still use a lot, which is that vaccines saved 20 million lives. I assume that the number has gone up, although I still use that figure. Simple messages like that might get through to people. Someone came into my office last Friday who was still very wary of the vaccines and needed some reassurance.

Humza Yousaf: We have to do our best to use the data that we have. For example, the World Health Organization commissioned a study—which a certain John Mason will know about—that showed that the vaccination programme saved well over 20,000 lives in Scotland. Given the recent autumn and winter booster vaccination programme, I am certain that that number has gone up. We need to rely on data and evidence and try to counter some of the misinformation. I am afraid that there are some people whom we will almost never be able to convince, but we can convince the vast majority, and that work will continue to rely on the strong evidence base for the vaccination programme.

We should also use as many different people as possible in society to get the message out. People might not trust politicians—shock, horror!—but we should make sure that we empower clinicians, as well as the people who have benefited from the vaccine, to speak about the benefits. Of course, all of us should make sure that we speak about the benefits of the vaccine and vaccination programme, as well.

Dr Harden: Evidence is now coming out that vaccination also reduces people’s chance of getting long Covid, so that is another reason for individuals—particularly the more susceptible individuals and those in the harder-to-reach groups—to make sure that they get the vaccine. As we learn more about long Covid, we start to learn about the things that can prevent it, and vaccination seems to be one of the things that reduces people’s likelihood of getting long Covid.

John Mason: Yes—I think that we had evidence earlier that a lot of the people with long Covid had Covid before there was a vaccine available. Is that broadly the case?

Dr Harden: That is pretty much the case. It is hard to know, because obviously we were not testing people for Covid at that time, so the link is harder to establish, but we saw a more rapid rise in long Covid cases from the first wave and wild-type virus variants. With subsequent variants, there has been less of a rise with each variant, but we have had vaccination in the mix as well, so it is harder to separate that out.

10:45

John Mason: On the theme of educating people, we would expect that, in the health service, there would be a good understanding of long Covid, but a lot of other employers, such as those in the private sector, might not understand the condition and what they could and should do to support employees. Is any work going on, or can any work go on, for employers, such as small employers who do not know an awful lot about the topic?

Humza Yousaf: We are doing work on long Covid with colleagues in fair work and employment. There are issues. Long Covid sufferers have told me that they did not have the most supportive employers. We are working with a variety of organisations to try to assist in that regard and to get the message out there. I have been heartened by the fact that the majority of interactions that I have had on business indicate that people have felt supported by their employers in relation to Covid and long Covid. However, that is not universal and it is not consistent enough.

We are engaging with employment colleagues. I can ask them to write to the convener with more detail about the actions that they are taking with employers in relation to long Covid, if that would be helpful.

John Mason: Okay, thanks.

Comparisons with myalgic encephalomyelitis have come through in the inquiry. ME has been around for 40 years—or, at least, it has been recognised for that length of time. We all know sufferers of ME. We have never found a cure for or an answer to it, and it has been difficult to pin down. Is that where we are going with long Covid—that it will continue to be incredibly difficult to pin down and we will probably not get one simple solution?

Humza Yousaf: I will go to the clinician to give a response to that, because it would not be right for me, without clinical knowledge, to assert what will happen in relation to long Covid and its comparison to ME and chronic fatigue syndrome. There are clearly some similarities in how the conditions present. The disbelief that Murdo Fraser referred to in his question we also sometimes hear from ME and CFS sufferers. However, if you do not mind, I will pass to Dr Harden to give a view on the question.

Dr Harden: Thank you for that, cabinet secretary.

Huge amounts of research are still going on to understand what is behind ME and CFS. There are parallels between some aspects of long Covid and ME and CFS. That is not surprising, because there is an association between ME and CFS and

previous viral infection. We know that certain viruses lead people to be more likely to develop ME or CFS. I imagine that a significant proportion of people who have long Covid are likely to have similar symptoms to ME and CFS just because they have had a significant viral illness.

That said, the research is now showing that multiple pathologies sit behind the symptoms that people get from long Covid. A recent article in *Nature* broke them down into five pathological processes, all with overlapping symptoms and signs. The difficulty is that, until we know how much each one plays a role in which symptoms and in which patients, it is difficult to know how best to treat individuals. We have to find out what the symptoms are, whether they are linked to long Covid and what pathology is going on in the individual's body, and then treat it with the treatment that works for that particular pathology. I guess that the chances are that we will find that it is not just one pathology process going on in individuals, but multiple processes going on in the one individual at the same time.

You are asking me to gaze into my crystal ball as a clinician, Mr Mason. I am a perpetual optimist. Medicine has come on in leaps and bounds in its drive to tackle the Covid pandemic and is in a different situation from where it was 75 years ago when the NHS was founded. That will continue. We will develop treatments for diseases but, sometimes, that will take longer depending on the complexity of the illness.

The Convener: We have a little bit of time left. If I may, I will go back to a point that Jackie Baillie touched on earlier, about the impact on health and social care services. Have we any figures on the number of NHS or social care staff who are currently off work as a result of long Covid? What action is being taken to address that?

Humza Yousaf: We should be able to get those figures to you. Forgive me—I do not have them at my fingertips, right now. If I am able to give them, I will be happy to share them with you, convener, for sharing with the rest of the committee. I think that that should be possible but, if you do not mind, I will take that off the table and see what we can provide.

The Convener: That would be great.

I will open up the questioning to members with supplementaries. Brian—do you want to come in?

Brian Whittle: I was just thinking about a point that Murdo Fraser made when he raised the potential advantages and disadvantages of having long Covid clinics. Have you considered that if we were to have such clinics where people with that condition, or who potentially have it, coalesce, one of the advantages would be an ability to gather data on it, because we would know where those people are.

Humza Yousaf: That could be the case, but in the absence of such clinics I do not think that we should take our foot off the pedal at all on data gathering. I agree with the first point in your question, which is that having such data will be vital for improving the services that we provide. For me, the challenge in having long Covid clinics from what I have read and seen from the various models across the UK—there is not just one model—is that they tend to end up being a bit of a middle man. [*Interruption*.] I hear a mobile phone ringing. It is like the Oscars: when you have talked for too long the music comes on and they tell you to get off. [*Laughter*.]

Jackie Baillie: You will be waiting a long time.

Brian Whittle: Oh!

Humza Yousaf: There was no need for that, Ms Baillie. [*Laughter*.]

There could be an advantage from such coalescing, but I do not think that it is necessary. I see from the Lanarkshire model that we have had well over 500 referrals—585 or thereabouts—so there is a rich data source.

Ashleigh Simpson would like to say more on that.

Ashleigh Simpson (Scottish Government): Thank you, cabinet secretary.

I want to add that the evaluation tool that will be developed by NHS National Services Scotland will be incredibly helpful in that. As we have already outlined, long Covid is essentially a new illness or disease, so we must learn about it and find out what works. We hope that the evaluation tool that is being developed will give us a better picture, both nationally and locally, about which people are getting it, its impact on them, and the impact of our services. That will help to shed more light on what is working and, more importantly, what is not working.

The tool will definitely help us to collect more data across Scotland. We hope that it will also help with the health inequalities aspect by showing us the demographics for which current services are working, who is not being engaged with, and where our services are not having the impact that they could have. More importantly, it will give us an evidence base to allow us to adapt and learn from what is working, and to encourage other health boards to pick up useful services.

The Convener: Thank you. As members have no further questions, that concludes our consideration of this agenda item and our time with the cabinet secretary. I thank the cabinet

secretary and his supporting officials for their attendance.

The committee's next meeting will be on 30 March, when we will consider our work programme and an approach paper on our inquiry into recovery of NHS dentistry services.

That concludes the public part of our meeting.

10:53

Meeting continued in private until 11:06.

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