**Witness Name: Caroline Lamb**
**Statement No.: 1**
**Exhibits: CL**
**Dated: 18 April 2023**

**UK COVID-19 INQUIRY**
**MODULE 1**

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**WITNESS STATEMENT BY THE DIRECTOR GENERAL FOR HEALTH AND SOCIAL CARE**

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**This statement is one of a suite provided for Module 1 of the UK Covid Inquiry and these should be considered collectively. In relation to the issues raised by the various Rule 9 requests served on the Scottish Government, in connection with Module 1, the Director General for Health and Social Care, will say as follows: -**

## Public Health in Scotland

### The Legislation

1. Health policy is devolved under the Scotland Act 1998 (as amended by the Scotland Act 2012), subject to specific and limited reserved matters (set out at Schedule 5 to the Scotland Act 1998), such as in relation to medicines. The Public Health etc. (Scotland) Act 2008 (the "2008 Act") sets out the duties of Scottish Ministers, health boards and local authorities to continue to make provision to protect public health in Scotland. These are without prejudice to existing duties imposed on Scottish Ministers and health boards in the National Health Service (Scotland) Act 1978 and existing environmental health legislation.

### The Structures

2. The *National Performance Framework* supports an outcomes-based approach to performance [CL/0001-INQ000102917]. Public health work is central to the delivery of several of the national performance indicators.

3. Up to the end of March 2023, four Ministers shared portfolio responsibility for aspects of public health: Cabinet Secretary for Health and Social Care; Minister for Public Health, Women's Health and Sport; Minister for Mental Wellbeing and Social Care; and Minister for Drugs Policy. Humza Yousaf was sworn in as First Minister on 29 March 2023, after which four Minsters were appointed with portfolio responsibility for aspects of public health: Cabinet Secretary for NHS Recovery, Health and Social Care; Minister for Public Health and Women's Public Health; Minister for Social Care, Mental Wellbeing and Sport; and Minister for Drugs Policy.

4. The Scottish Government has several public health divisions: Health Protection (which leads on the Infected Blood Inquiry), Health Improvement, Drugs Policy, Active Scotland and, since the pandemic, Covid Ready Society, Future Threats Surveillance, and Vaccines divisions. They are based within the Directorate of Population Health, which incorporates the Health and Social Care Analytical Services, and Strategic Capabilities Divisions, and which works closely with the Chief Medical Officer's Directorate. The dental public health strategic component falls within the Dentistry Division, under the Chief Dental Officer. All have a direct role in improving the public's health, as well as working with other areas of the Scottish Government which also have a direct contribution to make.

(Health) Emergency Preparedness, Resilience and Response (EPRR)

5. EPRR is a division within the Directorate of the Chief Operating Officer, within the Directorate-General Health and Social Care (DGHSC) and has been described by the Inquiry as a "Scottish Government Health Entity". The Directorate of the Chief Operating Officer came into being in 2022. It was previously called the Performance and Delivery Directorate. EPRR was previously named the Health Resilience Unit. From 2010 until April 2020, Michael Healy was unit head of this division. In April 2020, he became, and still is, the Interim Deputy Director. John Burns is the Director, coming in to post in July 2021 and John Connaghan was the Director in post when the Covid-19 pandemic began. John Connaghan returned from Republic of Ireland in January 2019 to take up the post of Director of Performance and Delivery. He became Interim CE of NHS Scotland in April 2020 on the retirement of Malcolm Wright. The Director General of DGHSC and Chief Executive of NHS Scotland is Caroline Lamb. One of the policy roles of EPRR is to support National Health Service (NHS) health boards in Scotland covering resilience areas. EPRR operates a system whereby it is on call 24/7 for emergency major incidents involving health

boards. In August 2013, guidance for health boards in Scotland was published entitled *Preparing for Emergencies: Guidance for Health Board's in Scotland*, which is provided [CL/0002-INQ000102971]. Each health board has its own CEO who is accountable to that health board and to the Scottish Government.

Flu Pandemic Strategy

6. EPRR was involved in the planning and being prepared for a flu pandemic. A team was set up in 2009 to undertake this work. EPRR worked with the UK Government and other devolved administrations in the UK. The *Pandemic Flu Guidance on Health Workforce Issues for NHS Scotland Boards* was issued in 2009 [CL/0003-INQ000102972]. The Pandemic Flu Readiness Board (PFRB) was set up in Scotland in 2017. From the end of the swine flu pandemic until the start of Covid-19, there was a limited requirement for advice being provided by the CMO Directorate in relation to pandemic (flu) planning. The primary reason for that is considered to be that, once the updated UK/4 Nations Pandemic Flu Strategy was agreed in 2011, there were, in reality, few decisions which required input from the CMO Directorate. A Communications Strategy was revised in March 2012 (as agreed by all four UK nations) and guidance (see document provided, headed *Department of Health, England and Health Departments of the Devolved Administrations of Scotland, Wales and Northern Ireland: UK Pandemic Influenza Communications Strategy Revision (2012)* [CL/0004-INQ000102973] was issued on behalf of all four UK nations as a companion document to the *UK Influenza Pandemic Preparedness Strategy (published on 10 November 2011)* [CL/0005-INQ000102974]. Views were provided by the CMO Directorate on a draft update to the pandemic flu guidance for health & social care in Scotland to health boards in 2019 for consultation. The process was not complete by the time of the onset of the Covid-19 pandemic.

7. In terms of resources available to Scotland in the context of planning and preparation for a pandemic, much of the work was done on a UK four nation basis, and so Scotland had access to UK intelligence, for example, the Scientific Advisory Group for Emergencies (SAGE) and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG). Modelling was done by the Scientific Pandemic Influenza Group on Modelling (SPI-M). SAGE was created primarily to provide scientific advice to UK Ministers during emergencies, but Scottish Ministers were also allowed access to that advice. NERVTAG

provided advice on some of the capabilities needed, including consumables and medicines (e.g. PPE and antiviral medicines).

8. Work to prepare for a pandemic was done on a UK four nations basis. Preparation focussed on planning for a flu pandemic on the basis of expert scientific advice. Infectious disease was however also identified and considered in the *Scottish Risk Assessment* [CL/0006-INQ000102940]. It was considered that the reasonable worst-case scenarios for flu would apply to other risks if they occurred, and preparations could be adapted. This was on the basis that in planning for an emergency focus was on the consequences i.e. the impact of a pandemic and not the cause. There was an anti-viral stockpile. FFP3 respirator masks were part of the PPE stockpile in preparation for a pandemic. In addition to having an adequate supply of PPE, the four nations did also have a "Just in Time" contract for FFP3 as a contingency (though the foreign supplier was prevented from fulfilling the contract by their government at the early stages of the Covid-19 response). PPE for Scotland and the other devolved administrations was procured through Public Health England. That was on the basis of economies of scale. The Barnett formula was used and as such Scotland took about 8.2% of the total required for the UK. It was then sent to Scotland and safely stored in a warehouse. It was procured by the Scottish Government for NHS and social care staff. Agencies, such as, for example, the police would have been aware that they required to have their own stockpiles of PPE for use in an emergency. There were also stockpiles of antibiotics and two antivirals, Tamiflu and Relenza.

9. As regards the 'expiration dates' of PPE, it was originally bought on a four nations basis and therefore similar products had similar use by dates across the four nations. Certain items of PPE are expensive and as a means to manage costs during the pre-Covid-19 pandemic period, consideration was given to extending the shelf-lives of certain products. In respect of FFP3 and facemasks, an approach was made at a UK level to the manufacturers to extend the shelf life. Manufacturers tested them to make sure they remained safe to use beyond their original expiry date. They also did an age simulation test, typically for three or five years. Those that were no longer suitable were not made available for use. In respect of those that had the manufacturer's seal of approval and remained suitable for use, the 'expiration date' was altered.

<u>NHS Scotland</u>

10. Most of the core public health workforce in Scotland is employed within NHS Scotland in the 14 territorial health boards and four national boards. The wider NHS workforce also makes a crucial public health contribution, including through the delivery of services, employment practices, leadership and resource allocation decisions, and partnership working.

NHS Territorial Health Boards

11. The 14 territorial health boards have corporate board-level responsibility for the protection and improvement of their population's health and for the delivery of frontline healthcare services. These boards have core functions under the 2008 Act in terms of public health. Each has a public health team led by a Director of Public Health (DPH). These public health teams are responsible for providing services across all of the domains of public health and for working in partnership within the health board and with external organisations and communities to improve population health outcomes. In a few areas, the DPH is a joint appointment between the NHS board and the local authority. Public Health Directorates within health boards vary in size, organisation and links.

Directors of Public Health

12. The DPH's role is central to the effectiveness of public health across the country, ensuring locally-sensitive responses to national priorities and policies. Thirteen functions are agreed to be part of the role of DPH. They are as follows:
    - Providing public health advice to the NHS board
    - Providing public health advice to the local authority
    - Contributing to corporate leadership of the board
    - Producing an independent annual report
    - Providing leadership and advocacy for protecting and improving health and reducing health inequalities
    - Managing the board's specialist public health team and associated support staff and resources
    - Ensuring the board and its staff have access to timely, accurate and appropriately interpreted data on population health

- Ensuring the implementation of NHS components of Scottish Government public health or health improvement policies
- Overseeing the coordination and effectiveness of screening programmes
- Communicating with the public via the media on important public health issues
- Contributing to emergency planning
- Ensuring all appropriate infection and environmental surveillance and control measures are in place
- Ensuring health needs assessments are carried out.

13. Additionally, DPHs meet collectively and have scope to ensure appropriate consistency of approach across Scotland.

NHS Statutory Bodies

14. The four NHS statutory bodies operating at national level with specific strategic roles impacting on public health are: Public Health Scotland (PHS), NHS National Services Scotland (NHS NSS or NSS), NHS Education for Scotland (NES) and Healthcare Improvement Scotland (HIS). There are four other NHS statutory bodies operating at national level: NHS 24, NHS Golden Jubilee, Scottish Ambulance Service and The State Hospital.

15. PHS is a special health board and was established by the Public Health Scotland Order 2019. It became operational in April 2020. It was created to consolidate the national public health functions of health protection, health improvement and healthcare public health, underpinned by data, intelligence and research functions. PHS is responsible for functions that were previously carried out by: Health Protection Scotland (previously a division of NSS), Information Services Division (also previously a division of NSS) and NHS Health Scotland (which was previously a national special health board, now dissolved). As part of the development of the target operating model for PHS, provided [CL/0007-INQ000102975], a number of commissions made recommendations on how the relevant functions should operate. The *Public Health Scotland Commission Final Reports* are provided [CL/0008-INQ000102976], [CL/0009-INQ000102977], [CL/0010-INQ000102978], [CL/0011-INQ000102979], [CL/0012-INQ000102980], [CL/0013-INQ000102981], CL/0014-INQ000102982], [CL/0015-INQ000102983], [CL/0016-INQ000102984] and [CL/0017-INQ000102985].

16. A commission report described the outcomes from stakeholder engagement events held by the protecting health commission in August and September 2018 [CL/0018-INQ000102986]. The commission worked with stakeholders and customers to understand and plan what was needed, thereby improving the 'Health Protection function', of working towards better health gains for people and communities. A further commission report outlined the existing arrangements and proposed future functional arrangements for the Protecting Health function within PHS [CL/0013-INQ000102981].

17. PHS is the national health improvement body which works with others in the public, private and third sectors to reduce health inequalities and improve health and wellbeing, emphasising preventative approaches. It is involved both in developing and disseminating evidence and in shaping policy and programmes to help achieve a fairer, healthier Scotland. It also delivers specialist national services and provides advice, support and information to professionals and the public to protect people from infectious and environmental hazards. In terms of information services, the organisation is driven by data and intelligence and provides a range of statistical information and analysis. It uses the full range of data – national and local, quantitative and qualitative – to offer vital intelligence to partners across the system.

18. NSS (which was formally known as the Common Services Agency) is a body corporate established under the National Health Service (Scotland) Act 1978. It provides a number of support services to the NHS and other bodies in Scotland. NSS also commissions and manages national screening programmes for Scotland and contains ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) Scotland, who are responsible for the surveillance and monitoring of infectious disease in the healthcare setting, and antimicrobial resistance.

19. NES is a special health board which provides education and training for those who work in the NHS in Scotland, including its core public health workforce, and ensures that the wider workforce's contribution to protecting and improving population health is supported.

20. Healthcare Improvement Scotland is a corporate body established under the National Health Service (Scotland) Act 1978. It is the national organisation responsible for

providing quality improvement support to healthcare providers in Scotland and for delivering scrutiny activity. It supports and delivers health and care activities which impact on public health, including evidence-based guidelines, public involvement processes, and health care quality and effectiveness assessments.

Scottish Public Health Observatory (ScotPHO)

21. The ScotPHO collaboration is responsible for providing a clear picture of the health of the Scottish population and the factors that affect it, including through improved collection and use of routine data on health, risk factors, behaviours and wider health determinants. It is led by PHS and includes the Glasgow Centre for Population Health and National Records of Scotland.

National Public Sector Bodies

22. There are also a number of public sector bodies with a specific public health remit which operate nationally in Scotland. They work with the NHS, Scottish Government, local authorities, business and industry, consumers and others. For example, Food Standards Scotland (FSS) is responsible for ensuring that information and advice on food safety and standards, nutrition and labelling is independent, consistent, evidence-based and consumer-focused. The Scottish Environmental Protection Agency (SEPA) is the principal environmental regulator, protecting and improving Scotland's environment.

Local Government

23. Local authorities in Scotland play a pivotal role in delivering preventative, universal services. They address the social inequalities which underpin health inequalities and improving health outcomes. They are a key partner in the overall effort to improve the public's health and prevent ill-health.

24. Local authorities also have statutory responsibilities under the 2008 Act in relation to the control of communicable diseases and must cooperate with health boards in certain cases (in particular, see ss. 4 and 5 and Parts 3 and 5 of the 2008 Act). They have prime responsibility for environmental health and employ core public health staff, most

notably Environmental Health Officers. Local government services also contribute to the public health function through important work within education, economic development, employability services, cultural and leisure services, and the physical and social environments.

25. The Convention of Scottish Local Authorities (COSLA) Health and Social Care Board provides a focus for COSLA's considerations of public health issues, with COSLA's Leaders' meeting setting policy.

Community Planning

26. There is one Community Planning Partnership (CPP) for each local authority area. Under the Community Empowerment (Scotland) Act 2015 public bodies work together and with the local community in CPPs to plan for, resource and provide services which improve local outcomes and reduce inequalities in the area. The Community Planning Improvement Board, with membership drawn from strategic leaders in public services and the wider community, helps to inform strategic policy direction for CPPs. As a matter of policy, CPPs are encouraged to focus efforts on addressing a small number of priorities for their area which reflect their understanding of the key needs and circumstances of the area and its communities (likely to include particular deep-rooted and entrenched social and economic challenges) and on which partners can make the most significant impact through effective joint working. Public health challenges frequently feature within these local priorities, either in their own right or as part of related themes.

The Third sector

27. There are a wide range of voluntary and community sector organisations with health interests, and even more with a focus on the determinants of population health. These all contribute to the wider public health function in Scotland.

Academic public health

28. Public health teaching and research takes place in all of Scotland's universities and many members of the core public health workforce are employed in academic public health within universities and research units.

Networks

29. A number of networks of public health professionals operate in Scotland to enable sharing of expertise, coordination of efforts and collaboration to undertake joint work. There are networks for specific disciplines, for special interests, geographical areas, and obligate networks, such as the Scottish Health Protection Network (SHPN).

30. The Scottish Public Health Network (ScotPHN) is accountable to the Scottish Directors of Public Health and PHS, and its role is to bring together the public health resources within the 14 territorial health boards, the national health boards, academic public health departments and wider public health agencies, including local authorities and the independent sectors. ScotPHN undertakes national prioritised pieces of work as well as facilitating information exchange. Given the size of Scotland, there is also strength in informal networks which operate (e.g., in a given field/speciality) where core staff know one another and can agree between them what activity needs to be undertaken and how to resource it.

UK Co-ordination

31. In previous years Scottish Ministers conferred on the UK Health Protection Agency (HPA) responsibilities and functions allowing the organisation to operate in Scotland. Following the abolition of the HPA by section 56 of the Health and Social Care Act 2012, Public Health England (PHE) was established in April 2013 as the expert service provider for the public's health in England. PHE performed the Secretary of State for Health's statutory functions in relation to public health under the National Health Service Act 2006.

32. Section 60 of the Health and Social Care Act 2012 provides for cooperation between bodies exercising public health functions. To allow PHE to perform functions required by the Scottish Government and PHS, agreement was sought from Scottish Ministers and a Memorandum of Understanding (MOU) reflected their assent to PHE operating in

Scotland. The MOU detailed the health protection services to be provided (specialist radiological and poisons advice), the way they should be provided and the relationships between the Parties.

33. The UK Health Security Agency (UKHSA) was formally established in April 2021 and replaced PHE in this role. It is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats.

International Health Regulations

34. UKHSA is the designated 'National Focal Point' for the UK for the International Health Regulations (IHR) 2005. The National Focal Point must be accessible at all times for communication with the World Health Organisation (WHO), both to consolidate and send information to WHO concerning the implementation of the IHR in the UK and to receive and disseminate information from WHO to those involved in surveillance and response in the UK.

35. When acting as the IHR National Focal Point, UKHSA's principal point of contact in Scotland is the Scottish Government, which liaises with PHS accordingly. In discharging this role, UKHSA agrees to liaise closely with both parties to share information and ensure their views and concerns are represented accordingly.

International Cooperation

36. In relation to the WHO, while there was not any direct relationship on pandemic planning, the WHO pandemic checklist was informally used to check that plans in Scotland were in line with the WHO approach. There was no significant direct engagement or co-operation by the Scottish Government with other international organisations in relation to pandemic (flu) planning. This was not deemed necessary. As far as those relationships took place via the UK Government, we were content for them – as the member body - to represent any opinions we had. Scotland, in cooperation with the other UK nations, had longstanding pandemic plans and preparedness measures in place – and had reviewed those after the swine flu pandemic. The Scottish Government was, for example, contacted by the UK

Government with regard to an initiative by the EU in or around 2011/12 in relation to joint procurement of pandemic (flu) specific vaccine and antiviral medicines. However, as the UK four nations had existing arrangements in place for these products (which were renewed around that time), the Scottish Government preferred to continue with those. Around the time of the swine flu pandemic, the Scottish Government, as part of a joint UK four nations initiative, donated doses of the pandemic vaccine to the WHO for use in developing nations. The Scottish Government will, of course, be keen to take advantage of all learning from Covid-19, both national and international, and will continue to work with its UK partners as necessary in that regard. That said, the Scottish Government does not believe that not having direct engagement/cooperation with international organisations made any material difference to our pandemic planning between 11/06/09 and 21/01/20.

Liaison with the European Centre for Disease Prevention and Control (ECDC)

37. The Secretary of State for Health had the lead UK role as the 'Competent Body' defined under EU legislation. The Secretary of State performed the following functions through PHE in the following areas:
    - Provided input to the ECDC Advisory Forum and other relevant groups
    - Reported to the European Surveillance System (TESSy) which incorporates the existing Disease Specific Networks and expands the range of surveillance to cover the list of organisms which each Member State must monitor and report on under the terms of the EU Directive
    - Sent alerts to and from Scotland in accordance with the ECDC Early Warning and Response System for communicable diseases (EWRS).

38. As part of the health security arrangements contained within the Trade and Cooperation Agreement (TCA), the UK and EU agreed to cooperation between the ECDC and the UK body responsible for surveillance, epidemic intelligence and scientific advice on infectious disease. On 1 December 2021, the ECDC and the UKHSA, signed a memorandum of understanding which aimed to strengthen the collaboration between the two agencies on matters of communicable diseases prevention and control.

Public Health Protection and Health Security Common Framework

39. In light of EU Exit, new UK-wide regulations replaced the EU legislative regime, and a Public Health Protection and Health Security Common Framework was developed (and received final approval on 18 August 2021), to set out arrangements for strengthening strategic and operational cooperation between the Governments and national public health organisations of the UK. Accordingly, both the Scottish Government and PHS are parties to the provisional framework.

40. The framework takes a broad approach to public health matters, covering threats from infectious diseases, as well as non-infectious hazards, such as radiation, chemical or biological threats. Arrangements covered by the framework include:
    - Strengthened UK-level communication and coordination of health protection activities, including policy development, public campaigns and messaging and expert committees
    - Principles for coordinated use of mutual aid
    - International engagement
    - Workforce
    - Education and training
    - Research
    - Data and intelligence.

41. Although the framework aims to develop common approaches to health protection and the sharing of expertise and resources, it also recognises and allows for the potential for divergence across nations. Scottish Government officials, together with their counterparts in the UK Government, Welsh Government and the Northern Ireland Executive worked jointly to develop this common framework.

42. The framework is governed through a tiered system of Senior Official, Strategic and Operational fora, comprising representatives from the UK Department of Health and Social Care, the devolved governments, and the national public health organisations. This tiered approach recognises that public health protection and health security relies on technical and policy input.

43. Four Nations Health Protection Oversight Group – this forum, which came into existence in late 2021, includes members representing the governments and public health agencies of each nation. It will progress implementation of the framework, the

associated Memorandum of Understanding and delivery of the work programme. It discusses information exchange, mutual support, sharing of best practice and oversight of operational working groups within the four nations. It is also responsible for the development of work plans to deliver the agreed work programmes, which may involve the oversight of time limited Technical Forums and/or Task & Finish Groups responsible for delivery of relevant work, as well as the UK Emergency Preparedness, Protection and Response (EPRR) Group. The Oversight Group meets four times per year and may have extraordinary sessions as required. The Chair rotates annually and is currently held by PHS.

44. UK Health Protection Committee (the Committee) – through the Health Security (EU Exit) Regulations 2021, the framework also establishes this group with senior membership from each nation's governments and public health agencies. It serves as the main forum for strategic level discussion and decision-making to monitor the application of the framework. The Committee is also responsible for several statutory functions as set out in the Regulations, for example, UK-wide surveillance of communicable diseases and related special health matters. The Committee meets bi-annually and is chaired by the Department for Health and Social Care.

45. The UK Chief Medical Officers (CMOs) Group acts as an additional senior-level body in the decision-making process where necessary and the UK Health Protection Committee is accountable to the UK Health Ministers.

**Public Health Reviews**

46. Several historic reviews have considered Scotland's approach to tackling health inequalities and how related resources are used. These include Audit Scotland's report on *Health Inequalities in Scotland (2012)* [CL/0019-INQ000102987], and *NHS Health Scotland's Health Inequalities Policy Review (2013)* [CL/0020-INQ000102988].
Both sets of recommendations confirmed the need for a clearer focus on the public's health in Scotland; greater coordination across structures and different levels of activity; and the need for partnership-based action informed by public health intelligence and evidence.

47. In 2013, the Scottish Government published *Equally Well* [CL/0021-INQ000102989]. This confirmed that Scotland's greatest health challenge continues to be the inequalities which exist between the poorest and richest in our society. Subsequently, in November 2014 Scottish Ministers announced that they had asked for a *Review of Public Health in Scotland*, the report of which was published in February 2016 [CL/0022-INQ000102990]. This review found that Scottish public health needed to be more visible and that it needed to have a clearer vision. It concluded that public health needs to provide leadership which extends far beyond the NHS and health boundaries to influence wider agendas, policies and programmes in the public, private, third and independent sectors.

48. The Public Health Review emphasised the cost-effectiveness of preventative approaches and the need for a more proactive public health effort in Scotland. The review group's recommendations were:
    - Further work to review and rationalise organisational arrangements for public health in Scotland, including greater use of national arrangements where appropriate
    - The development of a national public health strategy and clear priorities
    - Clarification and strengthening of the role of the DPHs, individually and collectively
    - Supporting more coherent action and a stronger public health voice in Scotland
    - Achieving greater coordination of academic public health, prioritising the application of evidence to policy and practice, and responding to technological developments
    - An enhanced role for public health specialists within community planning partnerships and Integrated Joint Boards
    - Planned development of the public health workforce and a structured approach to utilising the wider workforce.

49. These recommendations were translated into the relevant commitments within the *Health and Social Care Delivery Plan* published in December 2016 [CL/0023-INQ000102991]. This document set out a clear vision for the Health and Social Care system, including a more meaningful focus on prevention, and a recognition that there must be a more comprehensive, cross-sector approach to the public's health and wellbeing. The delivery plan also set out specific commitments to publish public health

priorities, deliver a new public health body and improve support for local health partnerships.

50. In 2017 Scottish Government and COSLA established the *Public Health Reform Programme* to take forward these actions [CL/0024-INQ000102992]. The programme set a vision for 'A Scotland where everybody thrives', with an ambition for Scotland to be a world leader in improving the public's health, using knowledge, data and intelligence in innovative ways and with an economic, social and physical environment that drives, enables and sustains healthy behaviours. A new national public health body, PHS, was to be created and have a key role in leading, driving, supporting and enabling change.

51. In June 2018, the Scottish Government and COSLA published Scotland's *Public Health Priorities*, following extensive work with a range of partners and stakeholders from across the whole system [CL/0025-INQ000102993]. The six priorities were:
    - A Scotland where we live in vibrant, healthy and safe places and communities
    - A Scotland where we flourish in our early years
    - A Scotland where we have good mental wellbeing
    - A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
    - A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
    - A Scotland where we eat well, have a healthy weight and are physically active.

52. These priorities reflected a widely held consensus about the public health challenges to be tackled over the next decade, in order to see the greatest possible improvement in the public's health and wellbeing. They provided a focus for all public services and wider partnerships across Scotland to improve and protect the public's health and wellbeing, reduce inequalities, and increase healthy life expectancy. They also provided a basis, consistent with the Scottish Government's National Performance Framework, to guide everyone working in the health system and beyond to align their efforts to make a real difference to the social conditions in Scotland.

53. Work to improve the public health system in Scotland continues in the context of the Care and Wellbeing Portfolio and the *Health and Social Care: National Workforce*

*Strategy*, published in 2022 [CL/0026-INQ000102994], which commits to actions to strengthen the public health workforce in the following areas: recruitment; workforce planning; specialist arrangements; leadership and succession planning; and workforce development.

54. The Care and Wellbeing Portfolio (CWP) is the main integrated strategic reform framework in DG Health and Social Care. It aims to bring coherence to, and accelerate progress on, efforts to improve population health, reduce health inequalities and create a more sustainable health and care system.

**Responsibility for oversight: an overview**

Scottish Ministers and Senior Officials

Key Ministers and senior officials over the relevant time period are listed below.

Cabinet Secretary for Health
Nicola Sturgeon – May 2007 – Sept 2012
Alex Neil – Sept 2012 to November 2014
Shona Robison – November 2014 to June 2018
Jeane Freeman – June 2018 to May 2021

Junior Ministers for Health
Shona Robison – Minister for Public Health – May 2007 to May 2011
Michael Matheson – Minister for Public Health – May 2011 to November 2014
Maureen Watt – Minister for Public Health – November 2014 to May 2016
Jamie Hepburn - Minister for Sport, Health Improvement and Mental Health – November 2014 to May 2016
Aileen Campbell – Minister for Public Health and Sport – May 2016 to June 2018
Maureen Watt – Minister for Mental Health – May 2016 to June 2018
Clare Haughey – Minister for Mental Health – June 2018 to May 2021
Joe Fitzpatrick – Minister for Public Health – June 2018 to December 2020

Director General and Chief Executive of NHS Scotland

Derek Feeley – 2010 – August 2013
Paul Gray – December 2013 – February 2019
Malcolm Wright – June 2019 to May 2020.
John Connaghan – Interim CEO – April/May 2020 to January 2021.
Elinor Mitchell – Interim DG – April/May 2020 to December 2020.
Caroline Lamb – January 2021 to date.

11 June 2009 to 31 March 2020

55. Health Protection Scotland (HPS) and Information Services Division (ISD) existed until PHS became fully operational on 1 April 2020, when the majority of its functions were transferred into PHS. HPS and ISD were divisions of NHS NSS, which was sponsored by the Director of Health Finance. NSS continues to exist. Therefore, the Director of Health Finance was responsible for the sponsorship of NSS and the NSS internal divisions, HPS and ISD, until those two internal divisions ceased to operate on 1 April 2020. Richard McCallum was appointed Interim Director of Health Finance and Governance in December 2019, and substantively appointed in March 2021. Christine McLaughlin was Deputy Director for Health Finance from February 2010 to December 2015, Director of Health Finance and Corporate Governance and Value from December 2015 to December 2019.

From 1 April 2020 onwards

56. As mentioned, PHS is a special health board and was established by the Public Health Scotland Order 2019 on 7 December 2019. It became fully operational from 1 April 2020. Most of the staff were transferred into PHS from NSS as of 1 April 2020. NHS NSS was formally known as the Common Services Agency. NSS continues to exist.

57. Given that HPS was involved in public health communications relating to the pandemic from January 2020 to 1 April 2020, for continuity and to avoid public confusion, the HPS 'brand' continued to be used after PHS became operational on 1 April 2020.

58. The responsibilities of accountable officers for parts of the Scottish Administration and accountable officers (AO) for public bodies are detailed in the accountability section of the *Scottish Public Finance Manual* [CL/0027-INQ000102908]. The essence of the AO's

role is personal responsibility for the propriety and regularity of the finances under their stewardship and for the economic, efficient and effective use of all related resources. AOs are personally answerable to the Parliament for the exercise of their functions.

59. The Permanent Secretary of the Scottish Government is the Principal Accountable Officer for the Scottish Administration. Reporting to the Permanent Secretary are the portfolio accountable officers (Director Generals). Sponsorship sits at a director level. For public health matters these are: The Director General for Health and Social Care is the Portfolio Accountable Officer for NHS Scotland, including the national NHS bodies PHS and NHS NSS. The Director General for Health and Social Care is currently Caroline Lamb. Caroline Lamb is also the Chief Executive of NHS Scotland. The Co-Directors of the Directorate for Population Health (Richard Foggo and Christine McLaughlin), and the Deputy Director for Health Protection (Sinead Power), have current responsibility for overseeing and ensuring effective relationships between the Scottish Government and PHS. Elizabeth Sadler and then Michael Kellet were in turn interim Director for Population Health from June to September 2020 and from October 2020 to August 2022 with sponsorship responsibility for PHS. Caroline Lamb, as Delivery Director for Test and Protect, had sponsorship responsibility for PHS from July to November 2020 supported by Jamie McDougall as Deputy Director. Elizabeth Sadler took on responsibility at DD level for Health Protection in March 2020 in addition to her role as Deputy Director for Health Improvement when Derek Grieve moved to work full time on Covid-19. Joanna Swanson was Deputy Director from July 2020 – January 2022. This relationship supports alignment of PHS's business to the Scottish Government's Purpose, National Outcomes and high performance by PHS. They work closely with the PHS Chief Executive and are answerable to the Portfolio Accountable Officer for maintaining and developing positive relationships with PHS, characterised by openness, trust, respect, and mutual support. Although PHS is legally accountable to Scottish Ministers, to reflect the crucial role of local government in public health matters, a joint sponsorship arrangement is operated with COSLA, which means that COSLA is consulted on all strategic decision-making and performance monitoring matters in relation to PHS.

60. Special advisers provide political advice to Ministers. Special advisers can be appointed at any point of a parliamentary term but are required to stand down prior to the election for the next parliamentary term. Noel Dolan was in post as lead health special adviser

from prior to June 2009 until 2012. David Hutchison was appointed lead health special adviser in 2012 and is still in post.

**Capacity, resources and funding of public health services**

61. The *2015 Review of Public Health in Scotland* [CL/0022-INQ000102990] examined public health systems and functions and their contribution to improving population health and reducing health inequalities in Scotland. This included an assessment of organisational arrangements and workforce capacity. The workforce themes and issues identified included the need to respond to the challenges associated with a dispersed workforce, involving varied skills and professions, to ensure a robust, resilient, and competent workforce of the future, with new talent attracted to the field of public health.

62. As part of the Public Health Reform Programme Commissions (2019) (as described at paragraph 15), that made recommendations on how the relevant functions of Public Health Scotland should operate, the *Specialist Public Health Workforce Commission* [CL/0017-INQ000102985] considered how the specialist public health workforce should be best organised in Scotland, to most effectively meet the needs of national, regional and local partners; and to deliver the most effective and efficient public health function for Scotland.

63. The *Leadership for Public Health Workforce Development Commission* [CL/0016-INQ000102984] looked at the wider public health workforce and quantified this across public services as potentially two million people. Workforce development needs were identified in the following broad areas which retain relevance post-pandemic:
    - Collective, collaborative leadership for public health
    - Personal effectiveness, values driven practice that complements technical skills
    - Whole systems theory and working practices
    - Empowering communities and 'upskilling' those who work in them
    - Public Health and inequalities knowledge and skills for core and wider workforce
    - Improvement and innovation – multi sector learning and shared good practice
    - Digital and data literacy, including valuing data from communities' experience

- Organisation development to clarify roles and find a common purpose and language across national and local agencies.

64. In 2021 Public Health Scotland worked with Directors of Public Health to understand better the needs of the core and specialist public health workforce, building on the learning from the pandemic, report provided [CL/0028-INQ000102995]. They highlighted:
    - Significant limitations in the workforce data and information to support fully public health workforce planning for public health
    - Data showed that 37% of senior level staff planned to retire in the coming five years, with urgent attention needed to be given to planning to ensure local organisational capacity for public health
    - That future public health workforce model and service delivery models would require to be flexible to ensure they are delivered in response to local needs and any future pandemic surges
    - The future workforce would require leadership support to sustain capacity, resilience, and capability in a changing working environment
    - Work needed to be undertaken to identify, assess and implement innovative options that would improve how we attract staff, build, and maintain workforce pipelines where the workforce supply is limited due to a shortage of skills or a competitive market and to accelerate and simplify the overall process where possible
    - Work was required to ensure the public health workforce had access to adequate workforce development opportunities to develop, support and maintain public health knowledge, and technical and soft skills.

65. DG Health and Social Care is provided with one overall budget. From March 2020, there was additional budgetary cover to support various aspects of the public health response – the Variants and Mutations (VAM) Plan is an example of this (discussed below).

66. Regarding the resourcing and funding of medical and/or scientific research, cases of Creutzfeldt-Jakob Disease (CJD) are monitored by the National CJD Research & Surveillance Unit (NCJDRSU), based at the Western General Hospital in Edinburgh.

The Scottish Government meets 10% of the annual funding requirement for the NCJDRSU.

67. Overall, high-consequence infectious diseases are dealt within existing NHS board budgets. However, PHS, health boards etc. liaise with the Directorate for Population Health and, where necessary, request additional funding for specific vaccines or communication campaigns. In particular, during Covid-19, the Scottish Government provided additional funding for vaccines, labs etc., although this was after 21 January 2020.

68. In the period to 21 January 2020, the Population Health Division, and its predecessors was not involved in monitoring and communication in relation to emerging diseases, insofar as their potential economic impact was concerned.

**Funding for public health bodies and services in Scotland**

69. Oversight, management and funding of the NHS in Scotland are devolved matters and responsibility for discharging these functions rests with the Scottish Government. Within the Cabinet, Ministerial responsibility within the time period was borne by the Cabinet Secretary for NHS Recovery, Health and Social Care, supported by the Minister for Public Health and Women's Public Health; the Minister for Social Care, Mental Wellbeing and Sport; and the Minister for Drugs Policy.

70. The total Scottish Budget is derived from the block grant from Westminster, as determined by the Barnett Formula. The Barnett Formula is used by HM Treasury to adjust the amounts of funding allocated to Wales, Northern Ireland and Scotland to reflect changes in public spending. It applies only to expenditure for devolved matters, including health. The block grant is then adjusted for i) tax revenues, for which the Scottish Government now has responsibility for raising and ii) social security funding which is wholly administered within Scotland e.g. Best Start and the Scottish Child Payment among others. The final element of the Scottish Budget is projected revenues from devolved taxes e.g. Land and Building Transactions Tax.

71. Where additional funding arises in England on public services, this will result in additional funding flowing to the Scottish Government through the block grant. Since

2010-11, the Scottish Government has committed to pass on any resource funding consequentials arising from spending decisions on health in England in full to the health and social care portfolio.

72. Health is the single largest area of Scottish Government resource spend, accounting for around 40% of the total resource budget. In comparison, health capital accounts for around 9% of total capital budgets.

73. The Scottish Health and Social Care Portfolio typically allocates around 70% of its total annual budget (resource and capital) as baseline funding to NHS territorial and national (formerly special) boards. This is provided to address national and local priorities for health and wellbeing services. As a large proportion of boards' annual spending is incurred on staff, the baseline funding allocations are uplifted each year to support known pressures e.g. impacts of pay awards and inflation.

74. There are 22 NHS entities in Scotland; 14 of these are territorial, or geographic, boards which cover the whole of Scotland; a further seven are national boards (previously known as special boards) which provide national services; and the final entity is Healthcare Improvement Scotland which provides scrutiny and public assurance on the operation of health services. A list of NHS boards is provided below:

| **Territorial Boards** | | **National Boards** |
|---|---|---|
| NHS Ayrshire and Arran | NHS Highland | NHS 24 |
| NHS Borders | NHS Lanarkshire | NHS Education for Scotland |
| NHS Dumfries and Galloway | NHS Lothian | National Services Scotland |
| NHS Fife | NHS Orkney | Golden Jubilee Foundation |
| NHS Forth Valley | NHS Shetland | Scottish Ambulance Service |
| NHS Grampian | NHS Tayside | Public Health Scotland |
| NHS Greater Glasgow and Clyde | NHS Western Isles | The State Hospitals Board for Scotland |

75. NHS boards in Scotland are all-purpose organisations which plan, commission and deliver NHS services for their local populations, including through independent

contractors such as General Practitioners, dentists, community pharmacists and opticians.

76. In 2016, the Scottish Government passed the Public Bodies (Joint Working) (Scotland) Act 2014 which created 31 integration authorities which are responsible for funding local services in health and social care which were previously separately managed by the 14 NHS territorial boards and 32 local authorities. Thirty of the integration authorities have been established as joint ventures known as Integrated Joint Boards (IJBs) with funding received from the respective local authority(ies) and NHS board on an annual basis. Highland operates a lead agency model whereby the board and local authority delegate functions between each other. Budgets for all IJBs must be agreed by 31 March each year between the integration authority, the NHS board and the local authority. The extent of delegated functions is set out within the local integration scheme which details how services are planned, delivered and monitored within each local area. In this way, money is passed from the NHS board to its IJB(s) in year to fund community services.

77. A list of integration authorities is set out below:

| **Integration Authority** | **Local Authority** | **NHS Board** |
|---|---|---|
| Aberdeen City | Aberdeen City Council | NHS Grampian |
| Aberdeenshire | Aberdeenshire Council | NHS Grampian |
| Angus | Angus Council | NHS Tayside |
| Argyll and Bute | Argyll and Bute Council | NHS Highland |
| Clackmannanshire and Stirling | Clackmannanshire Council; Stirling Council | NHS Forth Valley |
| Dumfries and Galloway | Dumfries and Galloway Council | NHS Dumfries and Galloway |
| Dundee City | Dundee City Council | NHS Tayside |
| East Ayrshire | East Ayrshire Council | NHS Ayrshire and Arran |
| East Dunbartonshire | East Dunbartonshire Council | NHS Greater Glasgow and Clyde |
| East Lothian | East Lothian Council | NHS Lothian |
| East Renfrewshire | East Renfrewshire Council | NHS Greater Glasgow and Clyde |

| | | |
|---|---|---|
| Edinburgh | City of Edinburgh Council | NHS Lothian |
| Falkirk | Falkirk Council | NHS Forth Valley |
| Fife | Fife Council | NHS Fife |
| Glasgow City | Glasgow City Council | NHS Greater Glasgow and Clyde |
| Highland | Highland Council | NHS Highland |
| Inverclyde | Inverclyde Council | NHS Greater Glasgow and Clyde |
| Midlothian | Midlothian Council | NHS Lothian |
| Moray | The Moray Council | NHS Grampian |
| North Ayrshire | North Ayrshire Council | NHS Ayrshire and Arran |
| North Lanarkshire | North Lanarkshire Council | NHS Lanarkshire |
| Orkney Islands | Orkney Islands Council | NHS Orkney |
| Perth and Kinross | Perth and Kinross Council | NHS Tayside |
| Renfrewshire | Renfrewshire Council | NHS Greater Glasgow and Clyde |
| Scottish Borders | Scottish Borders Council | NHS Borders |
| Shetland Islands | Shetland Islands Council | NHS Shetland |
| South Ayrshire | South Ayrshire Council | NHS Ayrshire and Arran |
| South Lanarkshire | South Lanarkshire Council | NHS Lanarkshire |
| West Dunbartonshire | West Dunbartonshire Council | NHS Greater Glasgow and Clyde |
| West Lothian | West Lothian Council | NHS Lothian |
| Western Isles/Cùram is Slàinte nan Eilean Siar | Comhairle nan Eilean Siar | NHS Western Isles |

78. A portion of the total annual health budget is retained within the Scottish Government for allocation across the Directorates of DG Health and Social Care during the financial year. Annual directorate budgets are agreed between finance and policy at the time of budget-setting and are based on estimated need, adjusted for historic spend and/or new policies. The budget is then used to provide: additional funding to NHS boards through in-year allocations; funding to other organisations, including third sector, in line with the overall strategic aims for health and social care; direct expenditure on DG Health and Social Care programmes; and/or to fund civil service staff and professional

advisors working within the Scottish Government to support health and social care in Scotland.

79. The current list of Scottish Government Health and Social Care Directorates is provided below:
    a. Chief Medical Officer
    b. Office of the Chief Nursing Officer
    c. Digital Health and Care
    d. Primary Care
    e. Health Finance, Corporate Governance and Value
    f. Chief Operating Officer
    g. Health Workforce
    h. Healthcare Quality and Improvement
    i. Mental Health
    j. Population Health
    k. Social Care and National Care Service Development.

80. In addition, some of the health budget is allocated annually to the Improving Health and Wellbeing Division which forms part of the Children and Families Directorate. This Directorate forms part of DG Education and Justice. Ministerial responsibility for the Division sits with the Cabinet Secretary for NHS Recovery, Health and Social Care.

81. It is the responsibility of the Directorate for Health Finance, Corporate Governance and Value to ensure there is effective financial management across all areas of the health system, including the Scottish Government Health and Social Care Directorates, including operation with the overall agreed Portfolio budget. This involves working with all areas of the system to agree savings targets, performance of regular budget monitoring and scrutiny; and assessment of future financial risks, challenges and necessary mitigations.

82. Prior to 11 June 2009, the 2008-09 Draft Budget (1 April 2008 to 31 March 2009) made specific provision for pandemic flu preparedness, including pandemic flu vaccine stockpiles. Successive budgets within the specified range of June 2009 to January 2020 have continued to include funding for i) pandemic preparedness/NHS board

resilience and/or ii) seasonal flu programmes. This funding is in addition to the baseline funding made available for NHS boards.

**The role of the Health Finance, Corporate Governance and Value Directorate**

83. The specific role of the Health Finance, Corporate Governance and Value directorate is to seek to achieve the best health and care outcomes for people by ensuring the best possible use is made of resources in the health and social care portfolio. The directorate is responsible for:
    - Financial strategy for the Health and Social care portfolio
    - Financial management of all 22 NHS (Territorial and National) Boards
    - Financial performance and financial advice to Integration Authority Chief Finance Officers
    - NHS infrastructure policy and investment
    - Delivery of the sustainability and value programme
    - Corporate assurance on information scrutiny and governance for the portfolio
    - Delivery of safe and effective quality prescribing and medicines use
    - Provide advice, insight and intelligence to Ministers and policy colleagues on cross-portfolio matters.

**Impact of the UK Departure from the EU**

84. As the date range of Module 1 relates to the period between 11 June 2009 and 21 January 2020 (which predates the UK's departure from the EU), the Directorate comments (in paragraphs 85-91 below) relate to the *preparation for potential impacts* of departure from the EU, rather than *actual impacts* of departure.

85. Work to prepare for the impact that the UK's exit from the EU (EU Exit) was likely to have on health and social care in Scotland, was coordinated within the Scottish Government by a small team, the EU Withdrawal Team, located within the Health Workforce Directorate. This team engaged with policy colleagues across the Health and Social Care Directorate General (DG), to identify key areas that would be affected by EU Exit. The policies identified that were likely to be affected included the following: medicines and medical devices regulation and supply; recruitment and retention of workforce as a result of the loss of freedom of movement; mutual recognition of

professional qualifications; reciprocal healthcare; health protection and surveillance; and medical research and clinical trials.

86. Work to prepare for EU Exit involved internal discussions across the DG and wider Scottish Government, including with Resilience Division, Health Resilience and the EU Exit Readiness Division; regular engagement with stakeholders, including health boards and social care organisations; as well as regular engagement with officials from within the UK Government and other devolved governments. Such discussions had the aim of assessing the risks, identifying potential mitigatory steps, and putting measures in place. Discussions included the identification of potential necessary legislation, as well as the exploration of non-legislative frameworks that might be used to govern engagement between the four nations, in policy areas that were previously governed by EU legislation.

87. This planning was 'stepped up' as the prospect of a 'No Deal Exit' grew, with a much greater focus on those critical areas that would be most immediately and directly affected (i.e., in the event that the UK left the EU without having an agreement in place). Taking account of the planning assumptions, the focus of planning and preparations moved towards those issues which would impact directly and immediately on people's health, and on the ability of health boards and social care organisations to deliver health and social care services. Significant effort was therefore made to ensure that, where possible, existing arrangements could continue and, where there was a risk of disruption (for example, to the supply chains and routes for medicines and medical devices), that the health boards and social care organisations put in place mitigations to ensure that Scotland's health and social care services had access to sufficient stock. The biggest risk was that disruption to supply routes, in particular in the short straits channel crossing through which the vast majority of medicines and medical devices travel, could lead to significant shortages in medicines and medical devices.

88. Significant aspects of medicines, licensing, regulation and supply is reserved to the UK Government. However, the Scottish Government had an important role in ensuring that the arrangements being put in place by UK Government would ensure no disruption to supply – and Ministers, who have responsibility for the delivery of healthcare services in Scotland, expected to be given assurances that plans and mitigations were in place so that services would not be impacted. Contingency planning was done by the UK

Government's Department of Health and Social Care (DHSC), working closely with all health departments across the UK. Planning involved a request to all medicines suppliers and wholesalers to increase their stockholding in the UK, so that they held at least six weeks additional stock (i.e., above normal stock levels held within warehouses in the UK) of all critical medicines. Additional warehousing, where needed, was provided. In addition, agreement was reached between governments that the NHS in Scotland would have access to the National Supply Disruption Response (NSDR) arrangements put in place by the DHSC for both medicines and medical devices, and to the UK Government's additional secured ferry capacity and express freight air service.

89. For medical devices, Scotland developed its own contingency plan, with NHS National Services Scotland National Procurement building up a stockholding of up to eight weeks, (i.e., in addition to normal stock levels) for a long list of medical devices in use across health and social care. Scotland also had access to 'escalation routes', in the event of shortages or supply issues, through the NSDR route established by the DHSC, as well as the freight routes put in place by the UK Government.

90. Alongside this focus on immediate 'No Deal' planning, officials continued to work on other potential impacts, including in relation to the management of cross border threats to health. Discussions took place on a four nation basis to consider mitigations and future arrangements, including the development of a non-legislative framework.

91. The focus in the period prior to 21 January 2020 was very much on 'No Deal' planning, rather than a consideration of the interaction between concurrent threats, such as the potential for a pandemic or other significant health event. Nevertheless, the preparations made for a potential 'No Deal' (including the increased stockholding of medicines and medical devices) and the relationships that had been fostered between governments during that period, were positive developments that helped officials as they began work on a pandemic response.

**The UK's departure from the European Union: impact on public health**

92. The UK left the European Union on 31 January 2020. The date is out-with the scope of response. However, following Britain's exit from the EU, a four nations process was established to explore areas where common frameworks between the UK nations would

be necessary, to ensure common standards or processes, that previously had been provided by EU law. Public health and health security was identified as one such area.

93. As a result, the four nations developed a wide-ranging framework that took an 'all-hazards' approach, covering pathogens, chemical, environmental and radiological threats to health. Its aim is to ensure a rapid, coordinated response to cross-border public health threats. All four health agencies and governments of the UK are signatories to the framework, and it is accompanied by health security regulations, which establish the Health Protection Committee; sets out surveillance and notification processes for certain specified diseases; and designate the UK Health Security Agency as the body to which such threats should be notified.

94. In practice, the framework and associated legislation has:
    - Ensured continued cooperation with the European Centre on Disease Control and Prevention and the European early warning and Response System (on a case-by-case basis), to a large extent maintaining processes for notification and surveillance that the UK were required to carry out prior to EU Exit
    - Established the Health Protection Oversight Group, which develops a four nations work programme in areas of common interest – current work items include harmonisation of notifiable diseases across the four nations; border health; and genomics
    - Established the Health Protection Committee, which, among other duties, oversees progress of the work programme.

**Population Health: A Scottish Government Health Entity**

95. The Directorate for Population Health has been described by the Inquiry as a 'Scottish Government Health Entity'. The way in which the Directorate evolved should be understood and is set out below. Ultimately, all Directorates share competence across the Scottish Government.

96. In 2009 the Chief Medical Officer (CMO) and Public Health Directorate was headed up by the then CMO, Harry Burns. Within the structure of this Directorate, there was a Public Health Division, which was led by Mike Palmer, Deputy Director. He moved posts in 2011 and was succeeded by Donald Henderson as Deputy Director for the Public Health Division. In 2015, Catherine Calderwood became the CMO for Scotland

(following a brief spell in 2014- 2015 when Aileen Keel was acting CMO after Harry Burns' departure). In 2015, the Public Health Division moved to the Population Health Improvement Directorate, where Andrew Scott was Director.

97. In 2016, Donald Henderson left his role as Deputy Director for Public Health and the Division was split into two separate Divisions: Health Improvement Division, which was headed up by Daniel Kleinberg (as Deputy Director from June 2016 until February 2019, with Elizabeth Sadler becoming Deputy Director thereafter); and Health Protection Division, with Gareth Brown as Deputy Director from June 2016 until February 2019, when he was succeeded by Derek Grieve.

98. On the 21st of February 2019, Richard Foggo became Director of Population Health Directorate following Andrew Scott's transfer to another post. Elizabeth and Derek continued in their roles throughout this period. In March 2020, Richard Foggo and Donna Bell became Joint Directors of Covid Health Response, leading this newly created Directorate. This was an important transitional structure (there was a period between March and June 2020 in which there was no Interim Director of the Directorate for Population Health, with responsibilities being undertaken by Deputy Directors).

**Population Health: Areas of competence**

99. Since 11 June 2009, the Directorate for Population Health and its predecessors have not enjoyed exclusive competence within the Scottish Government. All competence areas are shared across the Directorate General for Health and Social Care, and the wider Scottish Government, including with the CMO, Deputy Chief Medical Officer (DCMO), Senior Medical Officers (SMO), and the Chief Nursing Officer.

100. High-consequence Infectious Disease (HCID) policy is the responsibility of the Health Protection Division within the Directorate for Population Health. As a result, the Health Protection Team feed into work around large-scale health risk assessments.

101. Overall key preparedness and resilience functions lie with the Emergency Preparedness Resilience and Response Team, and beyond health with the Scottish Government Resilience Team.

102. The distinctions between diseases which are high consequence, emerging and novel, endemic, and those that have pandemic potential (and in some cases develop into pandemics) are complex. In practice, an existing or new pathogen with the potential to become a pandemic with catastrophic consequences will emerge as an outbreak, and the profile of the risk and the subsequent management will determine how it develops. In practice, before 2019 Scotland shared the 2011 Pandemic Plan [CL/0005-INQ000102974] with the other nations of the UK. That remains in place. That plan is based on pandemic influenza and, as with the response to Covid-19, a novel or known infectious disease will initially be dealt with under normal health protection policy and guidance, to the point when the need for different administrative and policy arrangements is identified. The subsequent arrangements made for responding to Covid-19 are the subject of much what follows, below.

103. Alongside HCID and the pandemic plan from 2011, there are now specific arrangements made for the administration and policy response to Covid-19.

104. Regarding HCIDs, the key operational document is the *Management of Public Health Incidents* guidance, [CL/0029-INQ000102996] published in 2011, and Scottish Government internal guidance on managing urgent and out of hours public health notifications.

105. For Covid-19, since in or around June 2022, the Future Threats and Surveillance Division lead on the governance arrangements for monitoring and responding to Covid-19. This includes the secretariat for the on-going Four Harms Group, as the main cross-Government governance for Covid-19 response. They do this with support from:

- Covid Ready Society
- Strategic Capabilities Division who lead on the policy on whole population Testing, contract tracing and supporting isolation
- Vaccination leading on vaccination policy.

106. In terms of wider consequence management, the wider Health and Social Care Director General leads on key aspects of management of the health and social care operational response.

<u>Scottish Government Expert Entities</u>

107. There follows an overview of the Expert Entities within Scottish Government. All offices described below maintain an interest in emergency preparedness, planning and resilience. In the period prior to the Covid-19 pandemic, information such as new guidance and training or event summaries was provided to all office holders for review and further comment as appropriate.

108. The CMO for Scotland has responsibility for providing policy advice to Scottish Ministers on healthcare and public health, leading medical and public health professionals to improve the mental and physical wellbeing of people in Scotland, providing clinical advice on professional standards and guidelines, investing in research, particularly related to the NHS and encouraging young people to take up jobs in the medical and public health sector. Between 2005 and 2014, the CMO was Sir Harry Burns. The acting CMO between April 2014 and February 2015 was Aileen Keel. Between February 2015 and April 2020, the CMO was Catherine Calderwood. From April 2020 to December 2020, Professor Sir Gregor Smith was acting CMO: in December 2020, he became CMO and is still in that role.

109. The DCMO for Scotland is responsible for supporting and deputising for the CMO and working closely with the Chief Scientist (Health) and other medical and administrative colleagues. There are currently two DCMOs in post: Professors Graham Ellis and Nicola Steedman. Their appointments commenced in September 2021 although Professor Steedman has been in post as an interim DCMO since April 2020. Professor Ellis is a member of the SAGE Social Care Working Group which is a subgroup of the wider SAGE secretariat with academic and policy colleagues from across the UK. Professor Steedman is an Honorary Consultant Physician in Sexual Health and HIV at the Regional Infectious Diseases Unit of the Western General in Edinburgh. Gregor Smith held DCMO post for period October 2015 to April 2020 when he became interim CMO and then substantive CMO in December 2022.

110. The Chief Scientific Adviser for Scotland (CSA) is responsible for providing expert scientific advice to the Scottish Government about science-related issues, evidence and new developments that may have an impact on its work, championing the use of science to inform policy development across the Scottish Government and supporting Scotland's science base. From 2006 to 2011 the post of CSA was held by Dame Anne

Glover and between March 2012 and December 2014 it was held by Muffy Calder. The post was vacant between December 2014 and June 2016 when Sheila Rowan was appointed and held the role until June 2021. The current CSA is Professor Julie Fitzpatrick having been appointed in June 2021.

111. The Chief Scientist (Health) for Scotland (CS) role is to identify, promote and encourage research which addresses the health and healthcare needs of the people of Scotland. From 2008 to 2010 the role was held by Sir John Savill. Between April 2012 and November 2017, the CS was Professor Andrew Morris. Between November 2017 and July 2022 the CS was Professor David Crossman. The current CS is Professor Dame Anna Dominiczak who was appointed in July 2022.

112. The Chief Veterinary Officer for Scotland (CVO) from 2012 (acting from June 2011) until the present is Sheila Voas. Prior to this Simon Hall held the post from 2009 to 2011. The CVO is responsible for providing veterinary advice to the Scottish Ministers and leading on animal health and welfare for Scotland. The role includes protecting human health through the control of zoonotic diseases (those which spread between animals and humans). Responsibilities also include preventing, controlling or eradicating notifiable diseases such as avian influenza, foot and mouth disease, rabies and TB, thereby maintaining or opening trade routes.

113. The Chief Nursing Officer for Scotland (CNO) has responsibility for matters including policy advice for Scottish Ministers and leading on infection policy and antimicrobial resistance. Between 2004 and 2009 the CNO was Paul Martin, and between January 2010 until November 2014 the CNO was Ros Moore. Between November 2014 and December 2020 the CNO was Professor Fiona McQueen (she held the role on an interim basis between November 2014 and March 2015). Professor Amanda Croft then came into post. The current CNO is Professor Alex McMahon who took appointment in December 2021 (having been in post on an interim basis since October 2021. The Deputy Chief Nursing Officer for Scotland (DCNO) supports the CNO. In 2009 Ann Jarvie held the equivalent post of Associate CNO, as did Margaret McGuire in 2010 and Karen Wilson between 2011 and 2012. From 2016 to 2021 this post was held by Anne Holmes. Diane Murray then came into post as DCNO in 2016 to 2021. Anne Armstrong is the present DCNO hand has been in post since April 2021.

114. The Scottish Science Advisory Council (SSAC) is Scotland's highest level science advisory body, providing independent advice and recommendations on science strategy, policy and priorities to the Scottish Government.

**Preparedness and resilience: Cross-government structures**

115. Since in or around June 2022, the Future Threats and Surveillance Division has led on the governance arrangements for monitoring and responding to Covid-19. It does this with support from:
    - Covid Ready Society
    - Strategic Capabilities Division, which leads on the policy on whole population Testing, contract tracing and supporting isolation
    - Vaccination, leading on vaccination policy.

116. In terms of wider consequence management, the wider Health and Social Care DG leads on key aspects of management of the health and social care operational response.

117. Policy for HCID management sits, in the first instance, with the Health Protection Division. This includes responsibility for management of either potential or confirmed cases. Where such a case results in potential impacts on NHS services or capacity, the Emergency Preparedness, Resilience & Response Team (EPRR) join in management activity to ensure service resilience is maintained. In all instances of potential or confirmed HCIDs, the CMO team, including DCMOs and SMOs, play a crucial role in advising policy. These processes are set out in an *On-Call Guidance* document which was created for the Ebola virus, provided [CL/0030-INQ000102997].

118. In 2018, an HCID subgroup was formed as part of the SHPN. This followed Exercise Iris, which was conducted jointly by EPRR and Health Protection division. More information on this group is provided below. However, in November 2019 the subgroup presented several recommendations to the Scottish Government. Some of these, for example around PPE, have progressed, but the majority were impacted by the pandemic, and the pausing of most SHPN activity. As the SHPN has now resumed, work on these recommendations is also recommencing, and will take account of Covid-19 learning.

119. In terms of preparing for Covid-19, from its initial outbreak to 21 January 2020, the Scottish Government had not established any committees, working groups or specialist bodies.

120. After 21 January 2020, the Scottish Government Covid-19 Advisory Group had its first meeting in March 2020. The Group was established to *"consider the scientific and technical concepts and processes that are key to understanding the evolving Covid-19 situation and potential impacts in Scotland".* The Group's full *Terms of Reference* and membership are published on the Scottish Government website and are provided [CL/0031-INQ000102998] and the Inquiry has been provided with all the group's papers.

121. The group applied the advice coming to the four nations from SAGE, and other appropriate sources of evidence and information, and used it to inform local decisions in Scotland during the pandemic.

122. Importantly, this was an 'advisory only' group. It did not have any decision-making powers. The group last met in February 2022. While the group is dormant, it can be reconvened if necessary.

**Preparedness and resilience: Co-operation with international organisations**

123. Overall, for international organisations (such as the WHO and the World Health Assembly (WHA)) it is the UK that has a seat, as a member state. Scotland is not a member state in its own right. Therefore, Scotland does not co-operate directly with the relevant international organisations. Nevertheless, the information provided by the relevant international organisations (such as the WHO and the WHA) is provided to the Health Protection Network and to the CMO.

124. The Scottish Public Health Network is a network external to the Scottish Government which reports to the CMO, and which the Directorate for Population Health works closely with. The Network is accountable to the Scottish Directors of Public Health and PHS. Its role is to bring together the public health resources within the fourteen territorial health boards, the national health boards, academic public health departments

and wider public health agencies, including local authorities and the independent sectors.

125. For the period to 21 January 2020, in respect of either high-consequence infectious diseases, or Covid-19, the Directorate for Population Health did not directly co-operate with:

- The Global Health Security Initiative (GHSI)
- The Working Group on Respiratory Viral Pandemic Threats
- The WHO and the WHA
- The European Centre for Disease Prevention and Control (ECDC)
- The Programme Budget and Administration Committee (PBAC).

126. Up to 21 January 2020, all parts of the UK were receiving information at the same time, enabling Scotland to consider their own policy response.

**Preparedness and resilience: Local Government**

127. Local authorities in Scotland play a pivotal role in delivering preventative, universal services, that address the social inequalities underpinning health, and improve health outcomes. They are a key partner in the overall effort to improve the public's health, and to prevent ill-health.

128. Local authorities also have statutory responsibilities under the 2008 Act in relation to the control of communicable diseases and must cooperate with health boards in certain cases. They have prime responsibility for environmental health and employ core public health staff, most notably Environmental Health Officers. Local government services also contribute to the public health function through important work within education, economic development, employability services, cultural and leisure services, responsibilities for the physical and social environments, and a range of other duties.

129. Although PHS is legally accountable to Scottish Ministers, to reflect the crucial role of local government in public health matters, a joint sponsorship arrangement is operated with COSLA. This means that COSLA is consulted on all strategic decision-making and performance monitoring matters in relation to PHS. The COSLA Health and Social Care

Board provides a focus for COSLA's considerations of public health issues, with COSLA's Leaders' meeting to set policy.

**Community Planning**

130. Under the Community Empowerment (Scotland) Act 2015, public bodies work together and with the local community in CPPs to plan for, resource and provide services which improve local outcomes, and reduce inequalities in the area. Further details on how CPPs operate are included at paragraph 26 above.

**Preparedness and resilience: inequalities and vulnerable groups**

131. The 2008 Act requires each health board and local authority to designate sufficient persons (known as health board and local authority "competent persons") for the purpose of exercising, on behalf of the board or local authority, the functions assigned to them in the Act, or any other enactment. The Public Health etc. (Scotland) Act 2008 Designation of Competent Persons Regulations 2009 set out the criteria of those who are eligible to be designated as competent persons under the Act.

132. PHS was constituted as a national special health board and was delegated functions by the Public Health Scotland Order 2019.

133. The Common Services Agency was established by the National Health Service (Scotland) Act 1978 and delegated functions by The National Health Service (Functions of the Common Services Agency) (Scotland) Order 1974.

134. NHS Education for Scotland was constituted as a national special health board and delegated functions by The NHS Education for Scotland Order 2002.

135. Healthcare Improvement Scotland was established by the National Health Service (Scotland) Act 1978 and delegated functions by The Healthcare Improvement Scotland (Delegation of Functions) Order 2016.

136. The Functions of health boards (Scotland) Order 1991 specifies the functions to be exercised by territorial health boards in Scotland.

137. The Food (Scotland) Act 2015 established Food Standards Scotland (FSS) on 1 April 2015 as the public sector food body for Scotland. The 2015 Act sets out the objectives, general functions, and powers of FSS, and provides for governance and accountability arrangements as a Scottish public body.

**Preparedness and Resilience: communication with the public**

138. If officials were notified (usually by HPS - which became PHS on 1 April 2020 – as discussed in paragraph 15 above) of an incident or outbreak of a high-consequence infectious disease, the Scottish Government's Health Protection Team took immediate responsibility for ensuring relevant policy areas, clinicians and communication leads within the Scottish Government (and where relevant Scottish Ministers) were aware of all the issues, and were prepared to act as necessary. Communication with the public included proactive press releases, reactive media lines, marketing material and social media activity.

139. PHS is a special health board and was established by the Public Health Scotland Order 2019, as set out at paragraph 15 above. PHS is responsible for functions which were previously carried out by: Health Protection Scotland (previously a division of NHS NSS), Information Services Division (also previously a division of NSS) and NHS Health Scotland (which was previously a national special health board, now dissolved). The majority of those staff were transferred into PHS from NSS as of 1 April 2020. NHS NSS is formally known as the Common Services Agency) NSS continues to exist.

140. The Scottish Government, along with PHS (formerly known as HPS) liaise closely during an incident but PHS, as public health experts, led on initial communication with the public (and professionals) regarding the public health impact of high-consequence infectious diseases. Advice has also been provided on NHS Inform. However, the Scottish Government, represented by the CMO, DCMO, Senior Medical Officers, CNO and the National Clinical Director, has often provided further communications in response to media requests. This is often in the form of reassurance and explanations where necessary. NHS inform provides user-centred and accessible health information to the Scottish public. This includes information about:

- Conditions

- Self-help advice
- Tests and treatments
- Healthy living
- Health rights
- Scottish services available.

NHS 24's digital team work closely with Scottish Government policy teams and clinical experts to produce high quality and factual health information that is easy for the public to consume. NHS inform ensures that the people of Scotland have access to health information that they can understand when they need it most. NHS inform ensures that the people of Scotland have access to health information that they can understand when they need it most.

141. NHS 24 works with its own clinical development and expert team to maintain and develop its self-help guides and online content. Where wider expertise is required, agreements are put in place with external experts to provide an assured way of managing content on NHS inform. If content is provided by external experts a Memorandum of Understanding (MoU) is drafted and agreed. It also requires an agreed approach to evaluation and improvement. MoUs will often be signed by the relevant Scottish Government policy officials who are supported by their own clinical advisors. The MoU covers:
    - Provision of up-to-date content
    - A commitment to updating it when required and regular review by the subject experts to support the updates that will become public facing.

142. The MoU is not a legal document but it's important to ensure governance is maintained and to demonstrate a commitment to working collaboratively together. The MoU outlines the roles and responsibilities of the Governance Leads and NHS24 as well as NHS24's content review workflow.

143. In all scenarios, past and present, the Health Protection Team's role is to ensure both the Scottish Government and PHS communications are connected, and that all messaging 'aligns'. Where the Scottish Government's communication lines are engaged, the Health Protection Team seeks clinical input from the CMO's Team, and any other policy areas as required.

144. The Scottish Government's precise role in public facing communications varies, depending on the circumstances and nature of the incident. It may be decided that it is best dealt with as a purely clinical matter for PHS, wherein the Scottish Government's voice might cause confusion, or undermine messaging. On the other hand, it might be considered that proactive or reactive communication lines are required, including the management of logistics, involving experts from PHS and Scottish Government.

**The Scottish Government and UK wide simulation exercises**

145. The Scottish Government took part in the UK independent review after the 2009/1-H1N1/swine flu pandemic, called the 'Hine' Review, provided [CL/0032-INQ000103010] and had involvement in the UK-led pandemic flu exercises – Winter Willow, Cygnet and Cygnus, provided [CL/0033-INQ000103011]. Exercise Cygnet was a short pre-exercise leading in to *Exercise Cygnus*. In Exercise Cygnus, Scotland only participated at the level of Scottish Government officials, who took part in the four nations co-ordination elements of the exercise. Though officials from HPS were also involved in an advisory capacity, no frontline organisations in Scotland e.g. health boards, local authorities, were involved. This was because the Scotland-only *Exercise Silver Swan*, provided [CL/0034-INQ000103012] had taken place the previous year involving such frontline bodies.

146. In July 2014 the Scottish Government was made aware of an Ebola outbreak, affecting Sierra Leone, Liberia, Guinea, and Nigeria. The WHO declared a Public Health Emergency of International Concern (PHEIC), requiring an international approach. Post incident, Health Protection worked with HPS and other UK bodies to conduct several activities aimed at enhancing processes and procedures, such as: funding of a new testing service for HCID in Edinburgh, updating of guidance for schools, universities, borders and immigration centres to align with PHE, as well as establishing three regional units for the management of possible or confirmed HCID. Internal reviews of HCID and Incident management guidance were conducted, and improvements implemented. These continue to be reviewed regularly. Additionally, in 2015, Health Protection Scotland published infection prevention and control guidance for an outbreak of MERS-CoV and Avian Flu, including the appropriate levels of PPE.

147. Some of the simulation exercises carried out in the UK were done without the involvement or participation of Scotland such as: Exercise Northern Light (which was a UK exercise specifically to look at capacity within the High-Level Isolation Unit at the Royal Victoria Infirmary in Newcastle during planned maintenance in 2016); Exercise Typhon (which was a command post exercise held on 22 and 23 February 2017 to review the effectiveness of Public Health England's National Incident & Emergency Response Plan during two concurrent enhanced incidents) and; Exercise Broad Street - delivered on 29 January 2018 to consider the future definitive HCID service in England. Any matters arising out of these exercises that were relevant to processes or procedures in Scotland, were discussed with PHS and taken forward as appropriate.

148. In relation to learning from Exercise Cygnus, the Scottish Government received the report. At UK Government level, this led to the creation of their pandemic readiness board, which in turn led to the creation of an equivalent Scottish Government pandemic preparedness board in 2017. The key Scotland-led pandemic exercise was Exercise Silver Swan in 2015. This was ultimately led by SG Resilience Division and had four strands – business continuity, excess deaths, heath & social care and national co-ordination, most of which had their own events as part of an exercise programme across Scotland. The exercise involved both national and local/regional bodies, with events being held regionally across Scotland. The exercise report, alongside the similar UK Exercise Cygnus report, fed into the creation and work of the Scottish pandemic flu board from 2017.

149. In Scotland, *Exercise Iris*, provided [CL/0035-INQ000103013] was held on 12 March 2018 to test NHS Scotland's response to a suspected outbreak of Middle Eastern Respiratory Syndrome (MERS-CoV), a high consequence infectious disease (HCID). This was a multiagency exercise involving Scottish Government, and NHS Scotland territorial and National Boards. Following the exercise, in September 2018, a HCID subgroup of the Scottish Health Protection Network (SHPN) was set up to look at preparedness for managing HCIDs. Establishing the Group ensured that Exercise Iris's findings could be considered alongside a more holistic view of the system for responding to HCIDs. The Group identified three priorities for its work:

- HCID PPE education and training
- Development of clinical pathways for the safe management of HCIDs in Scotland

- Public Health response arrangements and guidance.

150. A letter was issued by the Scottish Government to health boards in July 2019, which included a reminder of their obligations to ensure that sufficient numbers of staff are FFP3 fit tested and trained in the use of enhanced PPE. The Group reported its recommendations to the Scottish Government in November 2019, and these were welcomed by the then CMO at the time.

151. Work commenced to progress the recommendations. The Respiratory Protective Equipment Survey, which has been carried out since 2015, was expanded to capture data on training in the use of HCID enhanced PPE in Scotland; including the number and type of staff trained, and the methods and frequency of training. A unified PPE Ensemble for managing cases of HCIDs has been agreed and training resources for "donning and doffing" have been established, alongside posters on the recommended use of PPE.

152. In relation to any other local/regional pandemic exercises in Scotland, we are aware that most health boards in Scotland tested/exercised their own pandemic plans, in whole or in part – and alone, or alongside multi-agency partners, such as the local/regional resilience partnerships. Those organisations themselves should be able to provide more detail. One specific exercise we are aware of was *Exercise Odette*, organised by the Highlands & Islands Local Resilience Partnership in November 2017. A copy of the report has been provided [CL/0036-INQ000102999].

153. The Covid-19 pandemic disrupted activity within the SHPN. Many clinical and public health resources were re-focussed on pandemic response and the work of the SHPN was paused (including the HCID subgroup). Since reconvening, the HCID recommendations are now being taken forward once again. It is acknowledged that learning from Covid-19 must be taken into account, and implementation of the recommendations is being considered with this in mind.

154. Exercise lessons applied to a range of stakeholders across government, health, local authority and resilience partnerships. Following these exercises, a range of national and local pandemic documentation was updated, including:

- Local and regional pandemic response plans which have been kept under review and updated at various points since 2015
- The NHS Standards for Organisational Resilience were published in 2016 and reviewed in 2018
- Guidance on dealing with mass fatalities in Scotland was revised in 2017
- Good Practice Guidance For Setting Up And Managing Body Storage Facilities was issued in 2017
- Guidance on death certification during a pandemic was revised in 2017
- The Scottish Risk Assessment was issued in 2018
- National pandemic response and guidance documentation for health and social care was updated and issued for consultation in 2019.
- Pandemic Influenza Guidance for Infection Prevention and Control was updated in 2019
- Pandemic Influenza Communications Guidance was issued to stakeholders in Scotland in 2019.

**Forecasts and internal assessments: Chronology and summary**

155. Between 11 June 2009 and 21 January 2020, the Planning and Performance Directorate did not carry out direct forecasting for a pandemic. However, it regularly 'fed into' risk assessment tools used by the Scottish Government, designed to establish potential outcomes, and impacts of health threats. Where relevant it also engaged in UK Government led exercises. In relation to forecasts relating to Scottish Government Health Entities and influenza pandemics, the key reliance was on the standing planning assumptions used in the 4 Nations Pandemic Flu Strategy and drawn from the UK National Security and Risk Assessment (and its predecessors) – and these were also used in the *Scottish Risk Assessment (SRA) 2018* [CL/0006-INQ000102940]. Those figures include the 'Reasonable Worst Case' (RWC) scenario for an influenza pandemic, covering issues such as the number of symptomatic cases, numbers hospitalised, those in critical care and the number of deaths. Analysis was done to support pandemic exercise scenarios, related to impact on hospital beds available. Those UK-wide planning assumptions were included in the *2011 Influenza Pandemic Strategy* [CL/0005-INQ000102974] and operational guidance documents issued to the health sector to support local planning. In relation to financial impact, the UK and Scottish risk assessments cover a wider range of impacts from an influenza pandemic,

including estimates of economic impact. The SRA is prepared by the Resilience Division. Currently that division is headed up by Jim Baird. The Public Health Team would have been responsible for Chapter 2 which relates to HCIDs.

156. In the early stages of the Covid-19 pandemic, SAGE provided a series of forecast assessments and analysis that informed briefing and decision making for the Scottish Ministers. That was shared through the Cabinet Office Briefing Rooms (COBR) process. Papers would be issued (in advance of COBR) from SAGE directly, and/or SPI-M (Scientific Pandemic Influenza Group on Modelling), and discussed at COBR. This information could then be used by the Directorate for Population Health to inform the policy decisions made by Scottish Ministers.

157. In preparing for high-consequence infectious diseases, the Directorate has relied on the variety of exercises documented throughout this process, such as Iris, and on the expertise of infectious disease clinicians, the HCID subgroup, and Health Protection Scotland (now Public Health Scotland). In particular, analysis of HCID impacts informed the recommendations of the HCID subgroup.

158. As mentioned, the Directorate for Population Health jointly facilitated Exercise Iris, held on 12 March 2018, to assess NHS Scotland's response to a suspected outbreak of Middle Eastern Respiratory Syndrome (MERS-CoV). Following this, a High Consequence Infectious Disease sub-group of the SHPN was set up. This group was co-chaired by Dr Gill Hawkins from HPS, and Mary Stewart, Health Protection Team, Scottish Government. The SMO, Dr Andrew Riley, also attended.

**Management of HCIDs**

159. The process for managing HCIDs within SG is well established. Strong links exist between related areas of government, such as the EPRR and CMO teams, as well as with Public Health Scotland. The key operational document is the *Management of Public Health Incidents* guidance, published in 2011. SG also has its own internal guidance on managing urgent and out of hours public health notifications.

160. In relation to the Covid-19 pandemic, when Covid-19 emerged in January 2020, the initial response was managed by the EPRR team. However, as the potential scale of

the pandemic and required response became clear, processes were quickly put in place to increase the response. Initially, the Health Protection Team within the Population Health Division managed the Covid-19 outbreak, and the team was expanded. Once it was apparent that the situation was escalating, the Directorate for Covid Health Response was established, led by Richard Foggo and Donna Bell as Directors. Staff were recruited from across the Scottish Government, that led to the creation on 1 July 2020 of the Directorate for Covid Public Health, as mentioned above. Also, across the SG, several other specific Covid-19 Directorates were established (such as PPE).

161. Since in or about June 2022, the Future Threats and Surveillance Division has led on the governance arrangements for monitoring and responding to Covid-19. This is done with support from:
    - Covid Ready Society
    - Strategic Capabilities Division (which leads on the strategies of whole population testing, contract tracing and supporting isolation)
    - Vaccination (which leads on vaccination policy).

162. In terms of wider consequence management, the wider Health, and Social Care DG leads on key aspects of management of the health and social care operational response. An outline chronological *Narrative of Actions within the Health Protection Team/DCMO/SMO,HPS until 21st January 2020* is provided [CL/0037-INQ000103000].

**Preparedness and resilience: advice tendered by Expert Entities**

163. As mentioned, in response to an Ebola outbreak affecting Sierra Leone, Liberia, Guinea, and Nigeria, the Health Protection team worked with Health Protection Scotland and other UK bodies to conduct a number of activities designed to enhance processes and procedures. Further internal guidance was produced (2015, and subsequently updated) to support the internal response management. This is mentioned above in paragraph 146.

164. As mentioned, the Directorate for Population Health also jointly facilitated Exercise Iris, which was held on 12 March 2018 to assess NHS Scotland's response to a

suspected outbreak of Middle Eastern Respiratory Syndrome (MERS-CoV). A sub group was set up, and its recommendations were welcomed by the then CMO.

165. As mentioned, the Respiratory Protective Equipment Survey, was expanded to capture data on training in the use of HCID enhanced PPE in Scotland.

166. As mentioned, a unified PPE Ensemble for managing cases of HCIDs has been agreed; and training resources for 'donning and doffing' have been established. A letter was issued to health boards in July 2019, which included a reminder of their obligations to ensure that enough staff are FFP3 fit tested and trained in the use of enhanced PPE.

167. As mentioned, Health Protection Scotland published infection prevention and control guidance, in June 2015, for an outbreak of MERS-CoV and Avian Flu, including the appropriate levels of PPE.

168. A document is provided that outlines the chronological response by the Directorate for Population Health to the Covid-19 pandemic, up to and including 21 January 2020 [CL/0037-INQ000103000]. This document includes details about areas of co-operation across the Scottish Government.

169. Overall, up to and including 21 January 2020, no clinical advice was provided by the CMO, the DCMO (Gregor Smith) or the two Senior Medical Officers (SMOs).

170. On 9 January the Senior Medical Officers advised that it was a fast-moving situation, and an HPS alert was mainly for the clinical community. Accordingly, it was premature to inform Ministers. The DCMO agreed with the assessment that there was no need to alert Ministers, since there was no evidence of human-to-human transmission.

171. On 17 January, the DCMO advised Derek Grieve (of the Population Health Directorate) that the prospect of person-to-person transmission had been raised, that it was time to brief Ministers, with the caveat that the risk to the UK remains very low. Briefing was sent to Ministers at 16:36. A copy of the briefing is provided [CL/0038-INQ000103009].

172. On 20 January, the SMO agreed with HPS that the disease should be notifiable under the 2008 Act. Later, the SMO advised that the guidance produced by PHE for managing suspected cases arriving in the UK from China would be adopted by HPS and used in Scotland. Guidance would be provided by HPS to local Health Protection Teams on communication should a suspected case be identified in Scotland.

173. On 21 January the DCMO agreed with the proposal to update both the Cabinet Secretary for Health and Sport and Minister for Public Health, Sport and Wellbeing and the First Minister. It was agreed to issue this on the 22 January 2020, to await the declaration by the World Health Organisation of a Public Health emergency of International Concern.

174. On 22 January the first Scientific Advisory Group on Emergencies (SAGE) meeting took place.

**Action taken since March 2020 regarding new and emerging HCIDs**

175. Policy for HCID management sits, in the first instance, with the Health Protection Division (HPD). This includes responsibility for management of either potential or confirmed cases.

176. HPD has a working/support arrangement with EPRR as incidents progress. EPRR will respond at the point when a critical/major incident is declared. In such circumstances the National Response Group, chaired by John Burns Chief Operating Officer for Scotland will also respond.

177. The key activities to prepare include:

- Leading on Exercise Iris
- Establishment of the HCID subgroup
- Development of and engagement with the Manager of Public Health Incidents (MPHI) guidance
- Development and regular monitoring of internal process for management of urgent notifications
- Learning from real-world incident management, such as Ebola in 2014.

178. Since June 2022, the Future Threats and Surveillance Division has been established as a Division of the Directorate for Population Health which is responsible for planning for Covid-19. The Directorate has prepared for future threats from Covid 19 and any variants and mutations by developing the Variants and Mutations and Surveillance Plans, details of which are produced and lodged:

- *Public Health Scotland - Plans for SARS-CoV-2 variant assessment and response* [CL/0039-INQ000103001]
- The four harms process:
- *Covid Four Harms Group - Process Map - Covid Threat moves to High Threat Level - Process Map (DRAFT v0.5)* [CL/0040-INQ000103002]
- *Covid Four Harms Low Working Group Terms of Reference 2022* [CL/0041-INQ000103003]

179. The Standing Committee on Pandemic Preparedness was established in August 2021, with a remit to ensure that Scotland is as well prepared as it can be for future pandemics. The Committee's *Terms of Reference* are available on the Scottish Government website and are produced [CL/0042-INQ000103008].

**The Future: reviews, reports and lessons learned**

Internal or external reviews since March 2020

180. Significant resources were devoted to managing the pandemic. However, the HCID subgroup has now reformed, and is considering learning in light of Covid-19. This includes the running of specific workshops on transportation.

181. In relation to Covid-19, since March 2020 the Directorate for Population Health has done the following.

182. In July 2020, it asked PHS to review the Incident Management Guidance. It was lightly edited to reflect the country was in a pandemic.

183. The Directorate of Population Health, helped to prepare the report, *Lessons identified from the initial health and social care response to Covid-19 in Scotland* (that covered the initial six months of the response to the pandemic, and was published in August 2021). This is provided [CL/0028-INQ000102995].

184. The Population Health Directorate leads on planning for, preparing for, managing Covid-19, and providing advice to Ministers. To help provide that advice, the Standing Committee on Pandemic Preparedness (SCOPP) was established in or around August 2021. SCOPP's remit extends to:

- advice on preparedness for and response to future pandemics, but not to manage the response to future pandemics
- all aspects of preparedness in relation to public health and connected issues, but not to economic or wider aspects of preparedness not connected to public health
- Information about the Standing Committee is published on the SG website.
- The *Interim Report and Appendix* are provided [CL/0043-INQ000103004] and [CL/0044-INQ000103005]
- The First Minister wrote on 8 December 2022 to the Chair of the SCOPP welcoming the Interim Report and accepting its recommendations, provided [CL/0045-INQ000148755].

185. In June 2022, the UK and Devolved Administrations Board (UKDA), a four nations board attended by officials from the UKHSA, the Scottish Government, the Welsh Government and from Northern Ireland, commissioned the Scottish Government to lead on a four nations 'test, trace and isolate lessons learned' activity. The Directorate for Population Health has overseen and led the work, on behalf of the four nations.

186. This report was not intended to be a clinical review, or to provide evidence of the absolute impact on transmission of delivery models across Test Trace and Isolate (TTI). Rather, it was intended to provide a review of lessons learned to date. The framing of this activity was to consider a potential response in relation to high case numbers of Covid-19 in future where the clinical view was that the risk of population wide health harm remained broadly similar to the assessment of the risks at that time.

187. The scope of this 'lessons learned' activity is to provide a collective view across the four nations on:

- the efficacy TTI delivery models and their suitability, considering constrained budgets at this time and reduced population-wide health risks

- an overview of the various aspects of TTI and a literature review of the evidence base
- an assessment of aspects of TTI as part of winter preparedness/contingency and how its deployment might support resilience of key workforce groups.

188. To deliver this report, officials from Scotland, Northern Ireland, Wales, and England attended a weekly work group session between June and September 2022. Analytical input including the literature review activity and modelling was delivered by the Health and Social Care Analysis (HSCA) team within the Scottish Government, which led Covid-19 Test and Protect analysis throughout the pandemic.

189. The draft report remains in progress with officials continuing engagement and work to finalise it. In September 2022, UKHSA officials notified officials from Wales, Northern Ireland, and Scotland that their view was that the paper would not be put forward to the UK and Devolved Administrations Board, following the reconstitution of that board and revised governance from November 2022.
    - *Draft report – Four nations Test, Trace, Isolate lessons learned paper – work remains in progress* [CL/0046-INQ000103006].

190. It has produced the following Review, which is still in draft; Process review exercise undertaken for international travel regulations and policy [CL/0047-INQ000103007].

191. Scottish Government officials have participated and are participating in two key reviews which will feed into future pandemic policy/preparedness. These are the UKG-led reviews of pandemic/emergency planning countermeasures – and also the pandemic disease capabilities board. We do not attach further detail here as we are proceeding on the basis that the UK Government will have provided the UK Inquiry with full details of these. As mentioned in para 179 the Scottish Government has also established a Standing Committee on Pandemic Preparedness whose members include the CSA, CS and the CMO. This Committee is intended to be a permanent advisory group to the Scottish Government established to bring together scientists and technical experts to advise the Scottish Government on the future risks from pandemic and to ensure Scotland is as prepared as it is possible to be for these.

192. The *2011 UK/Four Nations Influenza Pandemic Preparedness Strategy* [CL/0005-INQ000102974] remains relevant in relation to future pandemic flu threats, albeit subject to current reviews in light of the Covid-19 pandemic experience.

**Changes to entities, structures, systems and processes**

193. A review has been carried out, commissioned by Public Health Scotland, of the SHPN, designed to ensure its form, structure and outputs remain fit for purpose. The Scottish Government contributed to this and has responded to the report.

194. As mentioned, the former First Minister has welcomed the Interim Report of the SCOPP in her letter of 8 December 2022.

195. In relation to SHPN, the Scottish Government has welcomed the recommendations of the review, whilst acknowledging that further work will need to be done to understand how they should be implemented.

**Further developments in preparedness and resilience**

196. As mentioned above, in 2019 the HCID subgroup provided a comprehensive set of recommendations to improve future resilience. Since then, it is acknowledged that significant learning has occurred because of Covid-19. The subgroup has now reformed, and work on the recommendations is once again being progressed.

197. Scotland's national respiratory surveillance plan and the 'Plan for monitoring and responding to new SARS-CoV-2 variants and mutations (VAMs)' are two PHS planning documents that inform national health protection preparedness work.

198. The COVID Four Harms Group brings together the views from across the four harms which are defined in the *Lessons identified from the initial health and social care response to Covid-19 in Scotland*, provided: [CL/0028-INQ000102995]. This incorporates the views of the CMO (either direct, or via clinical colleagues) on the overall threat level of Covid-19 in Scotland; relevant data across Harms 1 and 2; and any information relating to the threat of potentially dangerous variants and mutations. The group also provides governance, challenge and scrutiny of the various legacy

programmes. It will form the Programme Board to review plans, risks and issues and activity updates. It meets regularly, and so ensures that the Scottish Government is able to react to an outbreak, variant or mutation.

199. The *Process Map* [CL/0040-INQ000103002] attempts to map each individual phase of the Covid-19 threat level, moving to 'high' during the immediate period (Day 0 – Day 10). Included within these are the potential 'owners of actions' identified in each phase. Such preparatory work helps to step up the Covid-19 response at speed.

200. 'Desk instructions' have been filled out by the key departments that mounted a Covid-19 response. As staff move roles, and the Covid-19 dedicated teams reduce in size, the desk instructions ensure that any necessary restrictions, key files and documents are easily understood and accessible. Areas will regularly update their instructions.

201. As mentioned above, Scotland's primary plan for responding to a pandemic event, not related to Covid-19, remains the *2011 Pandemic Strategy* [CL/0005-INQ000102974], led by ERPP.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Signed**: Personal Data

**Dated**: 18 April 2023