Opening Statement for Module 2A on behalf of Public Health Scotland

THE ORGANISATION AND ITS ROLE DURING THE PANDEMIC

My lady has, of course, heard of – and indeed from - Public Health Scotland (or PHS for short). For those who have not, it may assist if I start with some brief remarks about the organisation and the work that it does.

PHS is Scotland's national public health body. It's a young organisation having only become operational on 1st April 2020 near to the start of the pandemic, and it originated in a programme of public health reform in Scotland.

Why was it created? The rationale for its creation was to establish a unified public health organisation with a focus on protecting and improving the health and wellbeing of Scotland's population, and, no less importantly, reducing societal health inequalities. As Professor Paul Cairney stated in his report recently provided to this Inquiry, PHS embodied Scottish Government's commitment and significant desire to address health inequalities nationally.

The objective of the organisation has been said to "provide a credible, independent voice based on evidence and professional judgement that can objectively assess and comment on the likely impact, benefits and risks to the public's health and wellbeing of policy proposals".

How then in practical terms does it do that?

It seeks to identify and understand what has been scientifically shown to improve and protect health and reduce inequality nationally. It then shares that knowledge with relevant persons and organisations. In carrying out its role it collaborates extensively with the private, public and third sectors.

In terms of who the organisation is accountable to, it is obviously accountable to Scottish Government ("SG"), but it is also accountable to local government reflecting the fact that public health requires action both nationally and locally. This dual accountability was a feature which, at the time of PHS's creation, was very well received within public health spheres, and viewed as a progressive policy initiative on the part of SG. But ultimately PHS is accountable to the people of Scotland. It works to protect and improve the health of Scotland's population and therefore acutely felt - and continues to feel – the terrible impact wrought by this pandemic.

It is also perhaps equally important to give an idea of what the organisation does not do.

For example, the organisation is not involved in many of the practical aspects of maintaining public health at a community or local level. Many of the steps to support the control of the pandemic at a local level were performed by public health teams within Scotland's fourteen territorial health boards.

Neither is PHS involved in regulation or inspection activities. Thus, it is a misconception held by some that during the pandemic PHS was responsible for inspecting care homes. That was not the case.

DURING THE PANDEMIC

During the pandemic PHS had a major role leading, and contributing to, Scotland's response across a range of areas. Its scientific knowledge and expertise were relied on by SG, and the organisation was widely viewed as a key source of data, information, and advice. That message is reflected in a number of the SG witness statements prepared for this Module which my lady will have seen. In relation to particular areas involving PHS working with, or supporting, SG and which PHS considers were particularly successful I would refer, briefly to four examples:

FIRST On modelling, PHS supported SG's modelling of future projections of the pandemic through the provision of data and intelligence on case numbers.

SECOND On national testing PHS advised the Scottish Government on the development of its national testing strategy as part of the wider national Covid-19 response and led the development of a whole genome sequencing service for Scotland.

THIRD On the importance of maintaining low levels of community transmission of Covid-19 in Scotland, PHS advised SG on the development and roll out of its Test and Protect programme and played a major role in the delivery of the national contact tracing service.

FOURTH in the digital medium, PHS shaped the digital infrastructure that supported the response. This included creation of the PHS dashboard and publication of weekly and other statistical reports. I will say something more about this later in this opening statement.

Three points worth highlighting.

FIRST Although Covid-19 has taken up a large amount of the organisation's time and resources since its inception in April 2020, its areas of work go significantly beyond Covid-19. Its work involves a broad range of public health matters.

SECOND In coming into existence at the start of the pandemic, PHS faced twin challenges. It went through an inevitable “bedding in” process associated with establishing itself as a new organisation. There were organisational issues to be addressed, but compounded by the pandemic and its effects which were overlaid on top. Of course, at the same time, the organisation also had the responsibility of being the lead public health body in Scotland’s national pandemic response.

In the early days of the pandemic the organisation faced a number of issues relating to this ‘bedding in’ period, including challenges around staff, information systems, governance and creating a new cohesive organisational culture from the three legacy bodies. Moreover, PHS's opening budget and staffing levels were not sufficient for PHS to deliver the health protection response required by the pandemic. Additional funding was helpfully provided by Scottish Government, but for a period, there was a shortage of personnel within PHS trained and experienced in pandemic response. Although PHS considers that, at an organisational level, it nevertheless responded well during that period, this was not without a cost. It recognises and acknowledges that this would not have been possible without the enormous dedication of its staff and their willingness to work long hours over sustained periods. That, combined with stressful working conditions, without a doubt, adversely

impacted on staff health and wellbeing - as indeed was the case throughout many parts of the NHS, local government and beyond.

THIRD At that time, a significant proportion of the organisation's expertise in relation to pandemic matters was held by a small group of individuals within the organisation, upon whom significant demands were placed throughout the pandemic. This fact underscores the need for the organisation to have been more resilient, a point highlighted in the PHS Lessons Learned Report which has been produced to the Inquiry.

I now want to make some more specific comments in relation to three topics: first, PHS's role in supporting Scottish Government in decision making, second, data, and third, guidance

1. PHS role in supporting SG in decision making

FIRST PHS's role was to support SG in its decision making. The organisation's role was not to take those decisions, nor did it decide the policy upon which they were based. The key policies which underpinned the Scottish Government's approach to the management of the pandemic were chosen by, and the responsibility of, Scottish Government. This was clearly correct and respected the lines of responsibility between advisor and the Scottish Ministers as the ultimate decision makers.

SECOND PHS gave SG scientific advice and, uniformly, it sought to do so on the basis of the best available data and evidence. During the height of the pandemic, PHS staff spoke

regularly to Scottish Government colleagues providing public health perspectives on issues as well as expertise. However, as the pandemic progressed there were times it was required to give advice at very short notice. This inevitably proved particularly challenging for the organisation.

THIRD In taking decisions SG applied a decision-making framework which became known as the "Four Harms" approach. The concept recognised that both the pandemic itself, and measures taken in response to it, could separately cause harm. Moreover, the harm caused was not all of the same type but, rather, could be categorised into four broad groups: 1. direct health harms caused by Covid; 2. broader health harms; 3. social harms; and 4. economic harms. The judgements and decisions made by SG around the four harms were often complex involving a difficult balancing exercise. Given the varied nature of the "harms", SG often required to consider a wide range of evidence and expertise to enable it to take informed decisions. This included input from local and national health boards, executive agencies, non-departmental public bodies, civil society and academia. It is noteworthy, that PHS's expertise was in public health and, as such, its advice was focussed on direct and indirect health harms i.e. harms 1 & 2, and particularly harm 1. In consequence, there were, quite properly, occasions when PHS's advice, being based on a more limited perspective than that of SG, was not accepted by SG. The phrase, "following the science" is one that has been used in this context. It is worth saying that the phrase is not entirely helpful, because, at best, it oversimplifies the decision-making process. All of that said, PHS's overwhelming experience of this process was that the Scottish Government considered the contributions it made with care and respect.

2. Data

The use of data was particularly important in the response to the pandemic and a number of initiatives proved very effective. Indeed, PHS was the primary source for data and intelligence on the pandemic. Daily figures were produced on the number of tests conducted, the number of confirmed cases, the test positivity rate, and mortality figures. Public reporting took place seven days a week, 365 days a year on both the PHS and Scottish Government websites.

There are 3 initiatives which PHS considers were very successful and worthy of note.

FIRST PHS developed a range of effective data and analytic outputs that included robust estimates of the number of people with Covid 19 in Scotland, hospitalisations, and deaths. Where possible, deprivation and ethnicity data, with information relating to underlying health conditions, were provided. The information was widely shared within UK organisations such as SAGE and the New and the Emerging Respiratory Virus Threats Advisory Group (or NERVTAG - bodies with which we are now very familiar in this Inquiry) but also with international agencies including WHO, the European Centre for Prevention Disease and Control (or ECDC) and the Centre for Disease Control and Prevention (or CDC) in the US. The sharing of information and data with international colleagues was invaluable and allowed assumptions to be tested whilst additionally giving early insights into new findings.

SECOND The PHS daily dashboard was considered by many, to be a very valuable tool. The platform allowed the public, local authorities, and SG to gain immediate access to Covid-19

data in an accessible, easy to use format that promoted understanding of the relevant information. As a testament to its success, it was accessed more than 50 million times during the pandemic. Such “data visualisation” was crucial in relation to SG’s communication with, and subsequent engagement by, the public. The dashboard was publicly available, updated daily, and often referred to in SG press releases and media appearances. It also improved over time as more data became available.

THIRD PHS worked with Edinburgh University to restart a data reporting system, the (Early Pandemic Evaluation and Enhanced Surveillance) or EAVE project. It had been used in the Swine Flu pandemic of 2009 but had been in hibernation since then. The project was renamed EAVE II and went on to gather vital intelligence about issues such as the spread of the disease, impact on health, and critically, vaccine effectiveness. The project received international attention when it published one of the first evaluations into the effectiveness of Covid-19 vaccinations. EAVE II findings showed that the Oxford -Astra Zeneca and Pfizer-BioNTech vaccines reduced the number of people being hospitalised with Covid-19. Randomised controlled trials had already shown the vaccines were safe and effective, but EAVE II provided the first evidence that it had an effect at a national level. Scotland's size and data infrastructure, plus the speed of the rollout of the vaccination programme, meant that the EAVE II consortium was the first in the world to be able to publish such findings.

The pandemic also highlighted data related areas where PHS considers there was, and is, room for improvement.

FIRST In relation to data collection, the current system is built on a suite of older technologies and could be significantly improved to increase resilience. For example, the ECOSS (Electronic Communication of Surveillance in Scotland) system was critical during the pandemic but was prone to failure due to the volume and speed of transactions.

SECOND The sharing of data across organisations was not straightforward because of variance in systems used. Routine sharing of data with, and by, trusted NHS authorities under updated information governance arrangements are essential. Progress was made during the pandemic but there is a risk that it may slip back.

THIRD The sharing of data between the four nations of the UK to support the management of incidents was challenging and continues to be.

Finally, access to reliable, timely data was not available from care homes. Having up to date intelligence on care home residents would have allowed linkage of laboratory data to care home residents, enabled quicker understanding of care home outbreaks, and supported an effective response.

3. <u>Guidance</u>.

Lastly, PHS was responsible for producing certain health protection guidance during the pandemic. The guidance had the important function of informing what action was necessary to combat Covid-19 infection and contained elements directed both to health protection and infection protection and control. However, the guidance served a further purpose. Its other important function was to operationalise Scottish Government policy.

In practical terms, to ensure the latter, during the pandemic PHS and SG agreed a process which was known as the "policy alignment check" process (or PAC, for short). Although well intentioned, it is fair to say that there were challenges associated with it. The PAC process introduced an additional layer into the existing process of developing and issuing guidance upon which frontline teams and services relied. Under it, the final sign-off of guidance was by SG - rather than by PHS. At times the process was slow, resulting in delays such that the guidance was not always produced timeously. On occasion, the guidance became out of date and the process needed to be started again. These issues came to light particularly in the context of care home guidance. The PAC process was a direct consequence of the NHS in Scotland having been placed on an emergency footing during the period from March 2020 to April 2022. PHS does not call into question the necessity for imposing emergency powers given the exceptional circumstances – indeed that was a political decision and one entirely for SG to make. However, it is important to recognise and acknowledge that, in consequence, there was an impact on PHS's independent voice for public health. For present purposes, PHS would observe that having an independent voice is vital to its role of protecting the public's health.

PHS is grateful to you, my lady, for the opportunity to make this opening statement. We will endeavour to be of whatever assistance we can to you and your team over the weeks to come.

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