Witness Name: Caroline Lamb
Statement No.: 1
Exhibits: CL6
Dated: 11 October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CAROLINE LAMB

In relation to the issues raised by the Rule 9 request dated 26 July 2023 in connection with Module 2A, I, Caroline Lamb, will say as follows: -

1. I am Caroline Lamb of Scottish Government, St Andrews House, Edinburgh. I qualified as a Chartered Accountant in 1989, and since then have worked in the private, third and public sector. In 2004 I took up a role in NHS Scotland as Director of Finance and Performance Management at NHS Education for Scotland (NES). I became interim Chief Executive at NES in November 2014 and was appointed as substantive Chief Executive in 2015. In December 2019 I joined Scottish Government on secondment, as Director for Digital Transformation and Service Engagement in DG Health & Social Care (DGH&SC).

2. I have prepared this statement myself by reference to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Information Governance Division.

3. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.

4. References to exhibits in this statement are in the form [CL6/number - INQ000000].

5. As referenced above, in January 2020 I had just started a role in Scottish Government as Director of Digital and Service Engagement in DGHSC. As the Covid Pandemic developed I combined this role with lead delivery responsibility in a number of areas: from mid-March 2020 to early May 2020 I was Delivery Director for ICU expansion; from early May 2020 to end of July 2020 I led the work to establish a comprehensive contact tracing system for Scotland; and from August 2020 to January 2021, I was Delivery Director for the Flu and Covid-19 vaccination programme. In all these roles my responsibility was not to take the decisions in relation to what we should do, but to ensure that once policy decisions had been taken they were implemented across our health and social care system, the teams that I led were responsible for overseeing readiness assessments, making available guidance to local systems and for providing data and information to Ministers that would enable them to assess the extent to which policy was being successfully implemented (e.g. number of people vaccinated by priority group). In January 2021 I was appointed as Director General for Health & Social Care and Chief Executive of NHS Scotland.

6. From January 2020 to January 2021, and prior to being appointed as DG for Health and Social Care and Chief Executive of NHS Scotland, I was a member/chair of the following groups:

Group	**Role played**
Health and Social Care Management Group (HSCMB)	Member
Health & Social Care Planning and Assurance Group (PAG)	Member
Directors Daily Calls	Member
SG/NHS Intensive Care Units Resilience Group	Chair
Test and Protect Steering Group	Chair

Flu Vaccine & Covid Vaccine (FVCV) Delivery Group	Chair
FVCV Programme Board	Member
FVCV Digital and Data Group	Chair

7. In my role as Director of Delivery for Contract Tracing I worked with Local Government representatives who had responsibility for support for isolation, to ensure that we could deliver end-to-end services. I also worked with Local Government representatives in the role of Delivery Director for the vaccination programme, to ensure that communications with local government were consistent and that we could draw on support from local government in relation to premises, staffing and accessing hard to reach communities.

8. From January 2021 when I was appointed as Director General for Health and Social Care and Chief Executive of NHS Scotland I was a member of the following groups:

Group	**Role played**
Health and Social Care Management Group (HSCMB)	Chair
DGH&SC Directors Regular Calls	Chair
Executive Team	Member
Corporate Board	Member
Four Harms Group	Member
Mobilisation Recovery Group	Member

9. I first became aware of Covid-19 in my official capacity around mid-January 2020 when officials, on the advice of clinicians, alerted Ministers to the potential impact of the virus. In my capacity as Director of Digital and Service Engagement, I met with my senior team to discuss our response to the emergence of a new infectious disease. In the period from mid-January to mid-March 2020 my focus was on procuring additional licenses and supporting the wider roll out of 'NHS Near Me', the video consultation service already in use in NHS Scotland. We also arranged for MS Teams to be used by DGH&SC staff, using the NHS

Scotland tenancy. This was invaluable in supporting virtual meetings and communications across Scottish Government (SG) and NHS Scotland in advance of SG adopting its own tenancy of MS Teams.

10. From mid-March 2020 I was asked to take Director responsibility for leading the work to surge ICU capacity. This was a clear indication of how seriously the SG regarded the threat of Covid-19 and its potential impact on NHS Scotland services: work began immediately to double and then triple our ICU capacity across Scotland. I still regard these preparations as having been essential, although fortunately we never came close to breaching ICU capacity.

11. I was not involved in any discussions around the NIKE conference, or the Six Nations rugby match that took place between Scotland and France in this period.

12. In the early part of the pandemic, and in line with 4 nations planning for a pandemic, SG were seeking to contain the spread of the virus, whilst also seeking to understand more about it. I do not recall there being any discussion within the SG of implementing the concept of 'herd-immunity'. My impression at the time was that there was close working with England and the other devolved nations at all levels and that SG was not curtailed by decisions of the UK Government at this stage.

13. I did not provide any advice in relation to how Scotland should respond to the Covid-19 pandemic during the period January – March 2020. As outlined above my role was to lead teams charged with the implementation of policy.

14. In relation to the operational delivery of policy, areas which worked well were the extent of collaboration between and across teams. During the period when I was working on the ICU surge DH&SC procured a UK ICU stockpile of ventilators and associated equipment which was available to the devolved nations on an allocated basis. Communications between DH&SC and NHS National Services Scotland (NSS) who procured equipment on behalf of NHS Scotland were good, with daily calls to update on equipment arrivals and to check the suitability of individual items procured for the stockpile against our requirements.

15. The delivery of both contact tracing and vaccination in Scotland was based on building on existing structures, supplemented by national capability. This involved extremely positive working across Scottish Government, NHS Scotland, Local Government and others, including the third sector. Policy officials engaged regularly with their counterparts in the other nations of the UK. The Test and Protect programme in Scotland utilized parts of the UK four nations testing programme in addition to local capacity. The UK Vaccines Task Force obtained Covid-19 vaccines on behalf of Scottish Ministers throughout the pandemic. As with other UK nations, the Scottish Government adhered to guidance from the Joint Committee on Vaccination & Immunisation (JCVI) although the Scottish programme was delivered at times through a different delivery mechanism and at a different pace. The Scottish Government also took advice from wider groups, for example, in relation to decisions to offer vaccination to incoming international students, advice was provided by policy officials in education, informed by clinicians.

16. Scottish Government moved from contain to delay in its approach to Covid-19 on 12th March 2023, when community transmission was confirmed in Scotland and the day after WHO had declared Covid-19 to be a pandemic. This led to the introduction of a raft of NPIs culminating in a national lockdown. This strategy was adopted in order to reduce the 'R' number (the average number of people that each infected person passes the virus on to) to below 1, in order to halt the growth of the pandemic.

17. At the time that the decision to impose a national lockdown was made, this was an unprecedented development, the situation was developing very quickly and it appeared that health services in other European countries (eg Italy) were becoming overwhelmed. In my view the decision to lockdown was made in a timely fashion given the need to build on lower impact measures that had already been taken (eg cancellation of large events); to have in place appropriate regulation and support mechanisms; and to ensure broad public support for such a widescale restriction.

18. In relation to the re-instatement of lockdown measures in January 2021, it is important to note that by that time the approach of SG had developed to enable the approach to NPIs to be tailored according to the state of the pandemic in different areas across Scotland. The position was kept under formal review on a minimum of a 3 weekly period and the data and evidence that was part of the assessment lead to most of Scotland being moved to Level 4+ in January 2021, with some island communities remaining at Level 3.

19. I did not play any direct role in providing advice on, or in reaching decisions concerning the imposition or easing of, or exceptions to NPIs. From January 2021 as DGHSC and Chief Executive of NHS Scotland, my role was to ensure that we had the capacity and capability within the DG to provide timely management information to Ministers, in relation to measures such as vaccination levels, case levels, hospital occupancy etc. I was responsible for overseeing policy officials and clinicians who worked together to provide advice to Ministers, and I was responsible for ensuring that that decisions made by Ministers were communicated to and effectively implemented by the wider health and care system.

20. Scottish Government adopted a 'four harms' approach to considering the potential wider health, social and economic impacts of NPIs and assessing the public appetite and willingness to comply with measures. This process facilitated debate and the preparation of advice to Ministers. From January 2021, as DGHSC and Chief Executive of NHS Scotland, I was a member of the Four Harms Group, which was chaired by DG Strategy and External Affairs, alongside clinicians and other HSCD Policy officials.

21. In April 2020, to aid transparency the Scottish Government published its *Framework for Decision Making* [CL6/001 - INQ000131025]. This document set out the four harms as follows:
    - Direct Covid-19 health harms – harms associated with contracting the disease
    - Broader health harms – the impact on the NHS and social care, and the knock on to the ability of the system to treat all illnesses.

- Social harms – the harms to wider society as a result of closures (of schools for example)
- Economic harms – for example through closure of businesses.

22. In May 2020 the Scottish Government published an update: '*Framework for Decision Making – Further Information*' [CL6/002 - INQ000131027]. This set out the various types of evidence being considered as part of the four harms assessment. The document '*Scotland's route map through and out of the crisis*' [CL6/003 - **INQ000261967**] published in May 2020 acknowledged that the harms caused by the pandemic were not being felt equally, and committed to providing additional support for those who need it and seeking to advance equality and protect human rights in everything we do.

23. Throughout the course of the pandemic various formal impact assessments were carried out, and the four harms group provided a fora for the discussion of the impact of the different harms on people with protected characteristics. There was also regular public engagement on different aspects of NPIs and the pandemic using polling, focus groups, telephone interviews and on-line consultations.

24. In my view there was strong communication, planning and sharing of information across Scotland in relation to the rationale for the imposition and easing of lockdowns and other NPIs implemented in Scotland over the course of the pandemic. The published documents providing detail on the Framework for decision making provided an open and transparent basis for a phased approach to varying restrictions based on data, and aligned to the WHO criteria.

25. There were numerous meetings and sharing of expert advice on the use of NPIs across the 4 nations. However there were also differences in the characteristics of each of the four nations (e.g. geography, socio-demographic profile, school term dates), differences in epidemiological conditions at particular times, and differences in the political standpoints of each of the governments – particularly when the role of judgement in decision making on NPIs was key. So, there were a number of significant differences in approach to NPIs across the four nations.

26. I did not play any direct role in relation to adoption of approaches in Scotland that diverged from the UK Government. I was party to some of the discussions and to the data and advice being used to support decisions being made by Ministers. In my view, where there was divergence in the Scottish Government approach, this was necessary and appropriate in view of the situation in Scotland at the time.

27. In my view divergent approaches worked well when the Scottish approach was clearly based on the *Framework for Decision Making* [CL6/001 - INQ000131025], and later in the pandemic on the SG *Covid-19 Strategic Framework* [CL6/004 - INQ000249320], which introduced the 'levels' approach to phasing. However, decisions on the level of funding available for Covid-19 services such as testing were made by the UK Government rather than being taken on a four nations basis. This created affordability problems where the Scottish Government considered, for example, that the transition away from measures should be longer. An example of this was the UK government decision in 2022 to cease testing in most circumstances.

28. In relation to consideration given to the impact of NPIs, including the national lockdowns, My role as DGHSC was to ensure that we had the capacity and capability within the DG to provide timely management information to Ministers, in relation to measures such as vaccination levels, case levels, hospital occupancy etc. I was responsible for overseeing policy officials and clinicians who worked together to provide advice to Ministers.

29. I am not aware of any instances where SG was restricted or prevented from understanding the full scientific picture.

30. I did not play any direct role in the use of public communications and behavioural management in the response to Covid-19.

31. In my view the daily briefings worked well and were an important source of trusted information for people. I consider that alleged breaches of rules and standards by Ministers, officials and advisors impacted on public confidence in the response to Covid-19. In my view this was very much contained to a

lessening of confidence in UK Government Ministers, officials and advisors rather than the Scottish Government.

32. I had no role in decision making or providing advice in relation to public health and coronavirus legislation and regulations.

33. I provided oral evidence to the following committees of the Scottish Parliament:

Date	Committee	Reason
27 May 2020	Health and Sport Committee	Supporting Cab Sec as Director of Test & Protect Portfolio on Covid-19 Testing. See official report, provided [CL6/005 – **INQ000315539**
11 February 2021	Covid-19 Committee	Supporting Cab Sec on vaccines. See official report, provided [CL6/006 – **INQ000315540**
11 March 2021	Public Audit and Post-Legislative Scrutiny (PAPLS) Committee	Audit Scotland's NHS Overview Report See official report, provided [CL6/007 – **INQ000315541**
7 September 2021	Health, Social Care & Sport Committee	Supporting Cab Sec re Health Priorities for new Government. See official report, provided [CL6/008 – **INQ000315542**

2 December 2021	Public Audit Committee	2020/21 Audit of NHS NSS and briefing on PPE See official report, provided [CL6/009 – **INQ000315543**
21 April 2022	Public Audit Committee	Audit Scotland's Social Care Briefing See official report, provided [CL6/010 – **INQ000315544**

34. I also provided written evidence as follows:

Date	Committee	Reason
19 March 2021	PAPLS Committee	Follow up from Committee appearance on 11 March 2021 with (1) Detail on the tenure in senior leadership posts in the NHS against Audit Scotland's recommended 5-year tenure; (2) Figure on how many deaths there has been from Covid-19; (3) Details on the Scottish Government investment in additional medical places focused on widening access for students from disadvantaged backgrounds.
18 November 2021	Public Audit Committee	Response to request for information on the provision of child and adolescent mental health services (CAMHS) in Scotland including a breakdown of the actions that have been taken against each of the 29 recommendations made by the Scottish Association for Mental Health and NHS NSS Information Services Division in its "Rejected

		referrals to child and adolescent mental health services audit", published in 2018 and variations in waiting times.
6 December 2021	Public Audit Committee	Response to request to provide more information on the national Flu and COVID-19 vaccination Health Inequalities Impact Assessment (HIIA), including the dissemination process that PHS undertook and a copy of the HIIA.

35. I consider that the key challenges in relation to the management of the pandemic in Scotland were in relation to standing up the infrastructure in order to deliver necessary public health responses (e.g. mass testing, mass contact tracing and mass vaccination). It is notable that advances in technology resulted in our being able to produce tests, including at home tests capable of being used at population level, and a vaccine that was effective against Covid in remarkably short timescales. However, the infrastructure necessary to implement these measures had largely to be built from scratch. We were also successful in rapidly developing data flows that enabled close to real time data on the progress of the pandemic, and of public health response (e.g. vaccinations).

36. I was involved in the lessons learned exercise that culminated in the report *'Lessons identified from the initial Health and Social Care response to Covid-19'* [CL6/011 - **INQ000147474** which was published in August 2021.

37. Better management of any future pandemic, regardless of the particular characteristics of that pandemic, will rely on the ability to rapidly ramp up key public health infrastructure as referenced above. Much of this has already been stood down a result of the withdrawal of UK Government funding. Whilst balancing cost against benefit is important, I would suggest that attention should be paid, at a 4 nations level, to agreeing what minimum levels of capacity in areas such as Testing and Contact Tracing should be preserved.

38. I was not a member of any informal messaging group (WhatsApp or other platform) that involved Ministers. I was a member of a number of WhatsApp groups that were used for communication between DGH&SC Directors, and other officials. These were used to alert members to issues that were arising and often to email messages that were in the system that needed to be picked up and responded to. None of these groups were used for decision making or recording decisions. I no longer have copies of the WhatsApp messages sent in the period covered by these request as, in line with my understanding of the *SG Mobile Messaging Apps policy* [CL6/012 - INQ000131069], these messages were deleted automatically after 7 days. Some text messages between myself and other officials are retained on my mobile phone and are being supplied to the Inquiry. To emphasise, no decisions were made via Whatsapp or informal messaging groups or text message. Any hard copy or electronic notes I took at the time have not been retained and have been securely destroyed in accordance with the SG Management Policy and Records Management Plan [CL6/013 - INQ000131067].

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: 11 October 2023