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UK COVID-19 INQUIRY
MODULE 2/2A

STATEMENT BY THE DIRECTOR GENERAL FOR HEALTH AND SOCIAL CARE

This statement is one of a suite provided for Module 2 and 2A of the UK Covid Inquiry and these should be considered collectively. In relation to the issues raised by the Rule 9 requests served on the Scottish Government, in connection with Module 2/2A, the Director General for Health and Social Care, will say as follows: -

INTRODUCTION

This statement is one of a suite provided for Module 2 and 2A of the UK Covid Inquiry and these should be considered collectively.

1. The Scotland Act 1998 made provision for a Scottish Government of Ministers, and a Scottish Parliament to which they would be accountable. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry in on 23 June 2023 sets out a detailed explanation of the competence of the Scottish Parliament and Scottish Ministers under the 1998 Act as amended by the Scotland Acts of 2012 and 2016 and other legislation. Those include broad executive and legislative competence over most aspects of health and social services.

2. 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 the Scottish Ministers and health boards in the National Health Service (Scotland) Act 1978 and existing environmental health legislation.

3. Currently four Ministers hold portfolio responsibility for aspects of health and social care; the Cabinet Secretary for NHS Recovery, 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.

4. Ministerial post holders for the period from January 2020 to April 2022 are listed below.

Cabinet Secretary for Health

- Jeane Freeman (Cabinet Secretary for Health and Sport) - June 2018 to May 2021
- Humza Yousaf (Cabinet Secretary for Health and Social Care) – May 2021 to March 2023.

Junior Ministers for Health

- Clare Haughey, Minister for Mental Health – June 2018 to May 2021
- Joe FitzPatrick, Minister for Public Health, Sport and Wellbeing - June 2018 to December 2020
- Mairi Gougeon, Minister for Public Health and Sport - December 2020 to May 2021
- Angela Constance, Minister for Drugs Policy – December 2020 to March 2023
- Maree Todd, Minister for Public Health, Women's Health and Sport - May 2021 to March 2023
- Kevin Stewart, Minister for Mental Wellbeing and Social Care - May 2021 to March 2023.

5. The Scottish Government's Health and Social Care Directorates (HSCD) are responsible for maintaining a high standard of care for the people of Scotland; providing support to Scotland's health and social care services and workforce; and improving the health of the population. HSCD is both a policy and delivery function with responsibility for the development of national policy for health and social care as well as the running of the National Health Service (NHS). HSCD is not solely focused on treating and preventing ill health. Its ultimate aim is to promote and sustain good health - complete physical, mental and social well-being.

6. The strategic direction for HSCD is guided by a number of key reports with common themes of person-centred services, world class care and delivering more care in the community. This is underpinned by priorities on digital enablement, financial sustainability and empowerment, and support of the workforce. These reports include:

- The Healthcare Quality Strategy (2010), (CL3/0001 - INQ000147332)
- The National Clinical Strategy (2016), (CL3/0002 - INQ000147333)
- The Realistic Medicine, Recovery Plan (as per the Chief Medical Officer annual report 2022), (CL3/0003 – INQ000147334)
- The Women's Health Plan (2021), (CL3/0004 - **INQ000147336**
- The Population Strategy (2021), (CL3/0005 - INQ000147337)
- The Health and Social Care national workforce strategy (2022), (CL3/0006 - INQ000147338)
- The Digital Health and Care strategy (2021) (CL3/0007 - INQ000147339)
- The Medium-Term Financial Framework (2018). (CL3/0008 - INQ000147340)
- The Health and Social Care Delivery Plan, launched in December 2016 set clear intentions where people need hospital care, day surgery to be the norm, and when stays must be longer, people to be discharged as swiftly as it is safe to do so (CL3/0009 - INQ000147341).

7. Addressing the determinants of health is not solely the responsibility of HSCD - cross-government collaboration is being driven through the promotion of a 'health in all policies' approach. This is reflected in work underway in areas such as the Drug Deaths Taskforce, homelessness, child poverty and early years programmes in education and justice. Such an approach recognises the significant contribution non-health policy can make to improving health outcomes.

8. During the pandemic, HSCD played a central role in the Scottish Government's response, mobilising and harnessing enormous support and effort from national and local partners – from NHS and social care staff, the scientific community to local authority and third sector partners.

ACCOUNTABILITY

Scottish Government

9. As specified by the Civil Service Code, just as Ministers are accountable to Parliament, civil servants are accountable to Ministers. The Director General for Health and Social Care (DG HSC) is Caroline Lamb. She has been in post since January 2021.

10. The DG HSC is a member of the Scottish Government's Corporate Board, the designated Portfolio Accountable Officer for HSCD, and the Chief Executive of the NHS in Scotland. As Accountable Officer, the DG HSC is personally answerable to Parliament and has a 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. Accountable Officers are responsible for putting in place frameworks for SG Executive Agency, non-ministerial office and SG sponsored bodies that set out their own accountability arrangements.

11. All DG HSC post holders from January 2020 to April 2022 are listed below.

Director General and Chief Executive of NHS Scotland

- 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.

12. DG HSC leads more than 1,700 staff across 11 directorates within the core Scottish Government and as DG HSC and Chief Executive of NHS Scotland has oversight of the health boards in Scotland. These directorates and agencies are responsible for putting Government policy into practice.

13. Directors-General (DGs) are responsible for families of directorates and the DG HSC line manages the Health and Social Care Directors and senior clinical advisers such as the Chief Medical Officer (CMO), Chief Nursing Officer (CNO) and National Clinical Director (NCD). The DG HSC delegates through the Scheme of Delegation, financial responsibility for particular budgets, and expenditure incurred against these budgets, to individual Directors.

14. The Directorates that contribute to the delivery of policy for health and social care, as well as the administration of the NHS, social care and public health systems include:

- The Directorate of the Chief Medical Officer
- The Directorate of the Chief Nursing Officer
- The Directorate for Chief Operating Officer, NHS Scotland
- The Directorate for Digital Health and Care

- The Directorate for Health Finance, Governance and Value
- The Directorate for Health Quality and Improvement
- The Directorate for Health Workforce
- The Directorate for Mental Health and Wellbeing
- The Directorate for Primary Care
- The Directorate for Population Health
- The Directorate for Social Care and National Care Service (NCS).

15. The list of Directorates listed above changed during the pandemic. Some Directorates were altered, with some new Directorates being added. Please see section on **Information Flow** at page 34 (paragraphs 119 onwards).

NHS

16. The National Health Service (Scotland) Act 1978 places a duty on the Cabinet Secretary to promote a comprehensive and integrated health service, designed to improve the physical and mental health and wellbeing of people as well as prevention, diagnosis and treat illness. The Cabinet Secretary may do anything which they consider is likely to assist in discharging that duty.

17. Scotland has 14 geographical health boards and six non-geographical special boards, supported by the NHS National Services Scotland (NSS) and Healthcare Improvement Scotland (HIS), that are accountable to the Scottish Government and Scottish Ministers.

18. NHS boards are legal entities established under the 1978 Act, with Healthcare Improvement Scotland later established under the Public Sector Reform (Scotland) Act 2010.

19. They are required by legislation to promote the improvement of the physical and mental health and the prevention, diagnosis and treatment of illness. To ensure the delivery of this, NHS boards are delegated responsibilities by the Cabinet Secretary to plan, commission and deliver healthcare services and take overall responsibility for the health and wellbeing of the communities they serve.

20. NHS boards' governance arrangements must be aligned to the Blueprint for Good Governance standards set by the Scottish Government. (CL3/0010 - INQ000147344). These focus on setting strategic direction, holding executives to account for delivery, managing risk, engaging with stakeholders and influencing organisational culture.

21. The NHS (Scotland) Act 1978 sets out both direction making and emergency powers that allow Scottish Ministers to secure the effective continuance of services. On 16 March 2020 the Cabinet Secretary for Health and Sport advised the Scottish Parliament that, under sections 1 and 78 of the National Health Service (Scotland) Act 1978, the national health service would be placed on an emergency footing for at least three months. The Cabinet Secretary set out that she was giving instruction to the NHS and individual health boards to do all that was necessary to manage the expected sustained increase in the number of cases of Covid-19 and signalled that, if required, new regulations would also be brought before Parliament to achieve that aim. This statement to Parliament was followed on 17 March 2020 by a letter from the DG HSC and Chief Executive of NHS Scotland to all Chairs and Chief Executives of health boards underlining that, in announcing the emergency footing, the Cabinet Secretary would utilise the direction making powers, where necessary, to instruct health boards to carry out certain actions in order to maintain the resilience of the NHS through the challenges brought by Covid-19.

22. Subsequently, the temporary Coronavirus (Scotland) Act 2020, passed on 1 April 2020, and the Coronavirus (Scotland) (No.2) Act 2020, passed on 20 May 2020. The Cabinet Secretary also made use of the direction making powers contained in Section 2 of the NHS (Scotland) Act 1978 on 4 June 2020 to seek assurance commitments on testing in care homes. Within the Coronavirus (Scotland)(No.2) Act 2020 powers were given to health boards to direct care home providers on matters related to Covid-19 to ensure appropriate standards of care. Further powers were included the Act to allow Ministers to apply to a court for an emergency intervention order (EIO) to nominate a person to act as a nominated officer to enter and occupy the accommodation, where there was serious risk to life, health or wellbeing. The Act also included powers for local authorities and health bodies to purchase distressed care homes or care at home service providers.

Social Care

23. The Scottish Government sets out the overall strategic framework and legislative basis for the delivery of adult social care. Local authorities have a statutory responsibility to provide the services.

24. The Public Bodies (Joint Working) (Scotland) Act 2014 requires local authorities and NHS boards to work together through Integration Authorities to plan, commission and deliver services. In the majority of cases, this is achieved through an Integration Joint Board (IJB). IJBs are responsible for the planning of adult social care services, as well as some health services and other functions. These services were previously managed separately by NHS boards and local authorities.

25. IJBs are jointly accountable to the relevant council and NHS board through their voting membership and reporting to the public. As distinct legal entities, IJBs are corporately responsible and accountable for complying with all relevant law when carrying out their services. There are also a number of regulatory bodies with an interest in the health and social care sectors that will scrutinise the operations of IJBs.

26. In Scotland, adult social care is delivered by a wide range of partners including the public, independent and third sectors. Services across the social care landscape are regulated by the Care Inspectorate who work with other scrutiny and improvement bodies, such as Healthcare Improvement Scotland (HIS), HM Inspectorate of Constabulary in Scotland (HMICS), HM Inspectorate of Prisons for Scotland (HMIPS), HM Inspectorate of Prosecution, Education Scotland, the Mental Welfare Commission and Audit Scotland to look at how social work and social care is provided.

Public and sponsored bodies

27. In recognition of the whole-system nature of Scotland's population health challenges, Public Health Scotland (PHS) was established 1 April 2020 and jointly sponsored and has dual accountability to both the Scottish Government and to local government via the Convention of Scottish Local Authorities (COSLA). This is a unique feature for a Scottish public body and requires a commitment to shared decision making, planning, and performance management in relation to the work of PHS. See the graphic provided for details of other relevant HSC public bodies.

Pandemic Planning

28. For many years, the Scottish Government, wider public sector and society has had in place law, policy and practice to prepare for, respond to, and mitigate the impact of a pandemic. The Scottish Government's response to Module 1 covers the planning for the potential impact of a pandemic virus including but not limited to influenza.

29. Within HSCD, co-ordination of pandemic flu preparedness sits with Health Emergency Preparedness, Resilience and Response (EPRR), formerly the Health Resilience Unit, as part of the Directorate for Chief Operating Officer.

30. The Public Health (Scotland) Act 2008 was created to reflect the nature of the interventions needed to deal with infectious diseases and pandemics. It complements a well-established legal framework for the protection of public health in Scotland. The Act places duties on health boards, local authorities, registered medical practitioners, directors of diagnostic laboratories, and occupiers or owners of premises in relation to the control of infectious diseases.

31. From January 2020 to April 2022, policy responsibility for the Act rested with the Health Protection Division within the Directorate for Population Health in DG HSC.

32. The Health Protection Division had responsibility for a range of policies beyond oversight of the 2008 Act including; screening, vaccination, blood and organ donation, sexual health and blood borne viruses, abortion, burials and cremations. Given the nature of the issues, the policy teams relied heavily on close collaboration with:
    - The Chief Medical Officer (CMO)

- The Deputy Chief Medical Officers (DCMO)
- The Senior Medical Officers from the CMO Directorate
- The specialist expertise of Health Protection Scotland and Information Services Division until Public Health Scotland became fully operational on 1 April 2020; and
- From April 2020, the specialist expertise within Public Health Scotland.

33. During the pandemic, HSCD also had an advisory function and contributed to the "four harms" decision-making process described in the the Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023, while directing the NHS in accordance with overall Cabinet decision making.

GOVERNANCE AND DECISION MAKING

Governance pre-pandemic

34. While Scottish Ministers have ultimate responsibility for all health and social care decisions made, there are clear governance structures and escalation points within the Scottish Government, HSCD, health boards and IJBs in order to best serve the people of Scotland.

35. The Scottish Cabinet is the main decision-making body for the Scottish Government. Cabinet business is bound by the Scottish Ministerial Code and operates using collective responsibility. The primary role of HSCD in relation to Cabinet is to provide advice to the Cabinet Secretary for NHS Recovery, Health and Social Care (previously Cabinet Secretary for Health and Social Care) and to draft and advise on papers going to Cabinet in the Cabinet Secretary's name.

36. The Health and Social Care Management Board (HSCMB) is the main decision-making body of the HSCD. The remit of the HSCMB is to be collectively and individually accountable for the strategy and performance of the NHS and HSCD, ensuring that resources are best used to respond to the priorities and deliver the best services possible for the people of Scotland. The Permanent Secretary holds the Director General/Chief Executive to account – with HSCMB being used as the vehicle by which the DG/CE discharges their functions.

37. HSCMB takes decisions on policy direction and financial commitments. It promotes robust assurance processes (risk management, financial and performance) for the NHS and provides assurances quarterly to Health and Social Care Assurance Board (HSCAB) that there are robust processes in place for risk management, financial and performance issues for both the DG family and NHS Scotland. For meetings during the pandemic, see paragraph 46 and 49.

38. Pre-Covid the HSCMB generally met on a weekly basis, including the period from January 2020 to March 2020.

39. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs, provided to the Inquiry in on 23 June 2023, draft on 28 February 2023 sets out a detailed explanation of the structure and accountability of the Scottish Government under the Scotland Act 1998.

Governance during the pandemic

40. The response to Covid-19 required an unparalleled, immediate and radical restructure of both services and ways of working across Government and most public services.

41. In order to tackle the virus, many aspects of the HSCD, NHS and social care services had to be flexible and adapt to a new normal. Structures and governance arrangements adapted and were altered at pace during the emergency phase of the pandemic.

Decision making pre-pandemic

42. Ministers usually take a decision or action based on written briefings (sometimes referred to as submissions or ministerial briefings). These briefings provide key information and advice on policy developments and issues. Submissions generally offer a range of options for Ministers to consider and include evidence on each option to ensure all implications are fully understood.

43. As set out in the Ministerial Code, decisions should be "informed by appropriate analysis of the legal considerations and that the legal implications of any course of action are considered at the earliest opportunity".

Decision making during pandemic

Scottish Government level

44. Strategic decisions relating to the response to Covid-19 were made by Ministers. DG HSC and HSC Directors, including the CMO/CNO/NCD/Chief Scientific Officer Health (CSO) were amongst the advisers who attended meetings where advice was discussed, agreed and submitted to Scottish Ministers. Officials from across HSCD provided a breadth of Ministerial submissions and advice across a wide range of key areas.

45. The CMO/DCMO, CNO and NCD regularly attended meetings with the First Minister, Cabinet Secretaries, Special Advisers, other relevant Scottish Government Directors and policy civil servants through a Director Briefing meeting.

46. There were daily meetings within DG HSC at official level (HSCMB; daily huddles with senior officials; Ministerial meetings etc). There were also weekly "Four Harms" meetings which often required pre-meetings with DG HSC Directors and senior clinicians (such as CMO or Deputy CMO (DCMO). Additionally, DG HSC held preparation sessions to support the Cabinet Secretary for Health's attendance at Cabinet (every Tuesday) or at Scottish Government Resilience Room (SGoRR).

47. In terms of pre-meeting briefing, where possible best practice was followed in terms of ensuring briefing was provided well in advance of any significant meeting to allow appropriate time for consideration and review. During the pandemic the pace of briefing increased substantially, and the time allowed for preparation and consideration of advice shortened accordingly. Submissions were used to communicate information and advice to ministers on policy developments and issues. Ministers made decisions or agreed action in response to a submission to best serve the people of Scotland.

HSCD level

48. The decision to reconstitute HSCMB to form the Health and Social Care Planning and Assurance Group (PAG) was taken on 24 March 2020. It commissioned and received relevant information, data and intelligence from the Military Planning Team and Covid-19 Division (acting as Operations Teams). PAG met on 11 occasions in total. On 13 May 2020, the Group agreed to revert to HSCMB by the end of the month and held its last meeting on 20 May 2020.

49. Finance and Risk were two items which continued to come to HSCMB for regular discussions. Following the publication of the Covid-19 Route Map, the agenda contained space for a discussion about the preparations for each review of the regulations. Decisions on whether the regulations could be further relaxed were not decisions which were made at HSCMB. When decisions were taken to relax regulations, HSCMB took decisions to ensure the health and social care system and services were in a state of readiness to respond to those changes.

50. Also, between 18 March and 6 April 2020, Directors' daily calls took place to provide updates and allow for rapid operational decisions to take place. Actions were recorded.

51. On 24 March 2020, DG HSC set out the intention to implement a strategic command structure; gold, silver and bronze commands with Health and Social Care Planning and Assurance Group (PAG) as a Strategic (Gold) level body which would temporarily replace HSCMB. The suggested approach was based on our ability to:

- Match provision to demand in the acute sector
- Ensure resilience and responsiveness in the community; and
- Maintain critical areas of business.

52. The model for this new approach and PAG's place within the governance structure are set out in the following paragraphs. PAG's role as Strategic (Gold) level drove the business at Tactical (Silver) and Operational (Bronze) levels. Assurance flowed back through the system to the PAG.

53. The Planning and Assurance Group (PAG) remit is set out below. Planning and Assurance Group was the reconstituted HSCMB for the initial phase of the Covid-19 crisis.

- The Group was collectively and individually accountable for the strategy and performance of the NHS and the HSCD, ensuring that resources were best used to respond to Covid-19, to save lives, protect the health and social care system and support Ministers.
- It took decisions on policy direction and financial commitments for Covid-19. It promoted robust assurance processes (risk management, financial and performance) for the NHS and the HSCDs.
- It determined which matters were delegated to other relevant stakeholders and groups.

- It commissioned and received relevant information, data and intelligence from the Military Planning Team and Covid-19 Division (acting as Operations Teams).

54. In order to allow the remit, standard operating procedure and papers to be prepared, the new PAG met for the first time on Monday 6 April 2020 and continued to meet twice weekly through to mid-May 2020.

55. PAG regularly reviewed the risks around the Health and Social Care response to Covid-19, and a number of the papers coming to PAG were specifically on a new approach to Risk. Military liaison colleagues assisted the development of this approach, and Scottish Government Non-Executive Director, Ronnie Hinds, was also engaged in this work.

Four Harms group

56. The Director of Covid Public Health, senior members of the Covid Public Health team, along with senior clinicians and other DG HSC Directors contributed to the Scottish Government's four harms process. This process facilitated debate around critical decisions in the context of the Scottish Government's framework for decision making which culminated in advice to Cabinet. The minutes of the Four Harms meetings or the subsequent Cabinet papers will express the constituent views in relation to the four harms. The four harms are as follows:

- **direct Covid-19 health harms** – primarily, the mortality and morbidity associated with contracting the disease
- **broader health harms** – primarily, the impact on the effective operation of the NHS and social care associated with large numbers of patients with Covid-19, and its knock-on effects on the treatment of illness
- **social harms** – the harms to wider society, in terms (for example) of education attainment as a result of school closures
- **economic harms**, for example through the closure of businesses.

57. For DG HSC officials and clinicians, this typically would mean in relation to harms 1 and 2. Cabinet minutes will record discussion and potential disagreement on the final decisions. The views of officials would be fed in at the Four Harms meetings, typically on a Friday, chaired by DG Strategy and External Affairs (SEA) and then fed in through the drafting process of the Cabinet paper for the subsequent week, typically Tuesday.

There were a few occasions when it was felt appropriate, to assist with Cabinet consideration, that senior clinicians (with support of relevant policy officials) or the Cabinet Secretary for Health, based on advice from officials, would provide separate advice.

58. Discussion of this advice by officials took place at the Four Harms meetings and then formed the basis of the Cabinet Secretary for Health's contribution to Cabinet decisions.

Communications within HSCD and records management

59. The Scottish Government has well established records management practices demonstrating compliance with Public Records (Scotland) Act 2011 (the PRSA), recognised as some of the most robust legislation in Europe. As required under the PRSA, the Scottish Government's Records Management Plan, provided: (CL3/0142-INQ000131067), is submitted to the National Records of Scotland Keeper of the Records and is reviewed annually, or sooner if changes to the law require it.

60. In accordance with the Scottish Government's Record Management Plan and Information Management Principles, decisions made by both Ministers and officials which form part of the Scottish Government corporate record are recorded. In addition, governance group meetings will normally have a formal minute taken and a note of any actions arising from the meeting. The minute will provide a collective summary of the discussion which took place at the meeting, and record key decisions and actions. Other types of meetings will not necessarily have a formal minute, if there are actions arising from the meeting or decisions taken at the meeting then it is usual for these to be recorded. In responding to the Covid-19 pandemic the Scottish Government was acting at pace with many meetings convened at short notice and actions being commissioned in real time, a record may therefore not exist. Generally, meetings within Scottish Government are not recorded either verbatim or via digital recordings.

61. The Scottish Governments Records Management Plan is published online and was updated in September 2022.

62. A key means of communicating within Scottish Government is by email. Those working for the Scottish Government, including Scottish Ministers, are provided with a Scottish Government email account. Email is used for a range of purposes including, internal

and external engagement with stakeholders, sharing information between policy teams and sending advice to Ministerial private offices. Emails which form part of the corporate record of Scottish Government business are required to be saved in the electronic record and document management system (eRDM). At the start of the pandemic users in Scottish Government had access to Skype, which operated as an instant messenger and means of holding audio and video calls. Messages were deleted at the end of each day. This was replaced in October 2020 by MS Teams. MS Teams offers in addition to audio and video calls the ability to instant message via chat and conversation. Chats are deleted after five days and conversations via a MS Teams 'channel' are deleted after three years. Any information created in these systems which forms part of the corporate record is required to be saved in eRDM. The interim MS Teams deletion policy for Scottish Government was included in the Module 2A DG Corporate statement provided on 23 June 2023.

63. To support the delivery of business the use of messaging applications such as 'text' or 'WhatsApp' is permitted. These applications are used for the quick exchange of information. There is Scottish Government guidance on the use of such applications, which requires key points and any decision to be recorded in an email or text document and saved in eRDM. The Scottish Government 'Mobile Messaging Apps Usage and Policy' document is provided on 15 February.

Co-operation and joint working with the UK Government and devolved nations

64. There were daily conference calls, set up by the UK Government (UKG) and attended by officials from Health Resilience and Health Protection forming the early Covid-19 response from January 2020. These included Healthcare Ministerial Implementation Group Health (Health MIG) (CL3/0143 - INQ000131023), Four Nations (CL3/0141 - INQ000147475) and Ministerial calls.

65. The Four Nations Health Ministers met regularly from 20 April 2020. a timeline of these meetings has been provided. Regular quadrilateral engagement also took place with UK Cabinet Office officials and DHSC officials who led on different policy areas at points from January 2020 to April 2022. There was also frequent engagement on a direct basis with each of the four nations at a policy level.

66. In addition to cooperation, the UK has a seat as a member state on international organisations, such as the World Health Organisation (WHO) and the World Health

Assembly (WHA). Whilst Scotland is not a member state in its own right, information provided by these relevant international organisations was provided to the Health Protection Network and the CMO.

67. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023 sets out information on wider intergovernmental liaison about the pandemic.

Co-operation and joint working with the UK Government on data analysis

68. Over the period in question, there were frequent Microsoft Teams calls held with four nations colleagues looking at data and analysis trends and policy proposals. These allowed discussion and ideas to be shared. However, no decision would be taken within the four nations call. Advice would be submitted to Ministers outside of the calls with the response conveyed at future calls. Where feasible, a four nations approach would be recommended.

69. Throughout the pandemic, Health and Social Care Analytics (HSCA) worked closely with counterparts (other analysts) in the devolved administrations to discuss Covid-19 data, generally in the context of four nations comparisons. HSCA were represented on Four Nations Vaccine Statistical meetings, which the DHSC chaired.

Co-operation and joint working with the UK Government on Non-Pharmaceutical Interventions (NPIs)

70. Within the UK, there was regular dialogue on the use of NPIs and, at times such as the initial lockdown and run-up to Christmas 2020, a significant degree of co-ordination. A shared basis for expert advice (e.g., Scientific Advisory Group for Emergencies (SAGE), the Joint Biosecurity Centre) and UK-wide approaches in related areas (e.g., on the 'furlough' scheme and in following Joint Committee on Vaccination and Immunisation (JCVI) advice in the vaccine roll-out) were factors tending towards consistency in approach across the four nations. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023 sets out information on wider intergovernmental liaison about the pandemic and details the decision-making by the Scottish Government relating to non-pharmaceuticals interventions (NPIs).

71. However, due to 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 – there were a number of significant differences in approach to NPIs across the four nations. For example, England had three nationwide lockdowns whereas Scotland technically only had one nationwide lockdown, though it came close to a second when only some island communities remained out of Level 4+ in early 2021.

72. The UKG held numerous meetings on the use of NPIs and shared expert advice. A more detailed response on this matter is provided through the CMO Module 2/2A statement provided to the Inquiry on 23 June 2023. These were primarily by Microsoft Teams calls. Most were for discussion and awareness not decision making. There was a set of weekly Whitehall led calls where devolved nations were invited to listen in and update on NPIs etc. These related directly to the UK Gold; Silver; Bronze structures. The CMO was invited to the UK Gold discussions and policy officials were on occasion also invited to listen into these. The Silver and Bronze meetings took place without devolved officials and the Whitehall meetings each week where devolved officials were present was really a readout of what happened at Bronze and Silver. In addition to established mechanisms for engagement with Cabinet Office, there were specific arrangements in place for engagement in relation to health policy matters including with DHSC.

73. Government representatives attended the Four Nations meetings virtually, and where appropriate informed Ministers of the policy intention of UKG. These updates were included in daily sit-reps to Ministers. Although there was regular dialogue on the use of NPIs and a significant degree of co-ordination, and divergence in approach due to geographical, socio-demographic profile differences in epidemiological conditions at particular times, decisions were implemented regionally.

74. In addition, policy leads would contact their counterparts in the devolved administrations on an ad-hoc basis as required. For example, the UKG organised and led policy leads meetings on various NPIs such as face coverings and physical distancing. There were daily conference calls, set up by UKG and attended by officials from Health Resilience and Health Protection forming the early Covid-19 response (CL3/0011 - INQ000147345).

Co-operation and joint working with the UK Government on ICU medical equipment

75. Caroline Lamb was also Delivery Director for ICU expansion from March 2020 to May 2020. ICU medical equipment planning to support ICU expansion was led by the SG/NHS ICU Resilience Group which includes representation from SG, National Services Scotland National Procurement, Scottish Critical Care Delivery Group, clinical engineering and Health Facilities Scotland, in consultation with NHS board critical care clinicians and clinical engineering leads.

76. In addition to the procurement of ventilators and equipment to support ICU expansion in NHS Scotland undertaken by National Services Scotland National Procurement (NP), as an additional layer of resilience available to us during the pandemic the DHSC procured a UK ICU stockpile of equipment and consumables which was available to the Devolved Administrations on an allocated based. Through joint working and regular meetings held by the DHSC, the DAs were kept up to date and informed on the availability of the UK stockpile as well as on any UK wide issues in relation to supply continuity which was being impacted on by the global demand for ICU medical equipment and consumables.

77. Up to 8.2% of the UK ICU stockpile was made available to NHS Scotland. While the majority of these supplies were not preferred NHS Scotland brands/specifications, NHS Scotland benefitted from a range of medical equipment that helped to bolster resilience across the service.

Co-operation and joint working with the UK Government on Shielding/Highest Risk Policy

78. For Shielding/Covid-19 Highest Risk policy, joint decisions were made at Four Nations' CMO calls. Calls were regularly held between the four nations, with counterpart Shielding/Highest Risk Policy officials in the UKG, Welsh Government and Northern Irish (NI) Executive coming together to share information and learning, and to discuss any areas of divergence.

The Joint Biosecurity Centre (JBC)

79. The JBC was established in summer 2020 by the UK Government DHSC to provide evidence-based independent analysis to inform local and national decision making in

response to Covid-19 outbreaks. On 10 August 2020, an agreement on the 'Participation of the Devolved Administrations in the Joint Biosecurity Centre' (hereafter referred to as the Political Agreement) was agreed between the Secretary of State for Health and respective Health Ministers in the Devolved Administrations. Following the completion of the Political Agreement, an Agency Agreement – underpinning the political commitment and providing the legal basis for JBC's operation on a UK-wide basis – was finalised at official-level and approved by Ministers. When the JBC was merged with Public Health England (PHE) and parts of DHSC, the JBC went on to form the Data Analytics and Surveillance directorate of the newly formed UKHSA in October 2021. The Agency Agreement has been extended and is still in place.

80. The JBC worked collaboratively with the devolved administrations to help inform public health responses in respective jurisdictions, although health is a devolved matter in Scotland, Wales and NI. The JBC provided analysis and assessments to decision-makers and did not take or direct operational decisions on outbreak response in any nation. The Agency Agreement extension and the Political Agreement governing this relationship underpinned the JBC's commitment to this approach.

81. Health ministers from all four nations attended the JBC ministerial board, and the devolved administrations were represented on the JBC steering board and the JBC technical board. The JBC was established to provide early warning of Covid-19, as defined by section 1 of the Coronavirus Act 2020, outbreaks across the United Kingdom. The JBC had three core functions:
    - Gathering and analysing data about Covid-19 infection to inform analytical products
    - Provision of assessment or guidance to help inform decisions about measures that it may be appropriate to implement to control the spread of Covid–19, and
    - Provision of advice on the Covid-19 alert level.

<u>Co-operation and joint working with the UK Government on Testing and Contact Tracing</u>

82. Caroline Lamb was delivery Director for establishing the **Contact** tracing and support for isolation programme from May 2020 to August **2020**.

83. Throughout the pandemic officials in the Testing and Contact Tracing Division engaged with counterparts from the devolved nations through the range of structures/meetings which are detailed in this statement. In addition to this, infrequent communication by email took place to discuss matters relating to testing, contact tracing and isolation both

to understand decision making and evidence base(s) in other nations and to ensure that officials could brief Scottish Ministers on decisions and the response that was being progressed in other nations.

84. In relation to the Testing and Contact Tracing policy and delivery engagement with counterparts in other nations of the UK was undertaken regularly and information on policy choices in other nations provided to the Scottish Ministers for awareness. Engagement through the structures set out enabled officials from all four nations to share emerging policy thinking and identify where there were any differences in the likely approach to be adopted in each nation (and share that information with Ministers as part of the decision-making process in Scotland). Some decisions taken by the UK Government had an effect on funding available to the Scottish Government and where this was the case, those impacts were considered as part of the decision making and policy development process and were able to be discussed on a four nations basis through the meetings and structures that were in place.

85. Test and Protect utilised parts of the UK's four nations testing programme, in which devolved nations received a share of services instead of Barnett consequential funding. This means that when the UK Government acted to expand or reduce the scope of testing, it had an impact on the Scottish Government's available capabilities. Further explanation on the Barnett consequentials can be found within the Module 1 Director General Exchequer statement, provided to the Inquiry on 19 April 2023.

86. Meetings that Scottish Government participated in, involved the four nations, are provided in the following table:

Meeting	Formal decisions at meeting?	Additional information	Additional informal processes?
Four Nations' Health Ministers' call	No. High level discussion between health ministers and updates from respective nations.	Ministerial level meeting to discuss a range of health issues, often including Covid-19 related matters. Frequency varied from weekly, to fortnightly to monthly.	A rough agenda is sent out by Secretary of State private office in advance, with input from DG offices if anything they wished to raise should be added. No official minutes or actions are taken but there are unofficial internal notes /distributed by SoS private office
UKG-DA Board	No. Though discussions in relation to formal decisions (or decisions to be made/escalated) are had. UKG Secretariat shared minutes, actions, etc.	Senior official meeting to discuss the four nations' testing programme. UKG-DA secretariat holds minutes, action logs and Terms of Reference (ToR).	UKG-DA engagement team will often organise targeted "breakout" meetings based on discussions in this call, e.g., finance, operations, policy, etc. The UKG-DA Board has had short-life working groups or extra meetings running between the monthly call. For example, in relation to facilitating the smooth transition for all nations for the National Testing Programme or; reviewing outcomes and implications for a spending review.

Meeting	Formal decisions at meeting?	Additional information	Additional informal processes?
Change Board (renamed the Strategy, Prioritisation and Change Board)	No. Though discussions in relation to formal decisions (or decisions to be made/escalated) are had. UKG Secretariat shared minutes, actions, etc.	Chance to raise issues directly with UKG senior officials. Focussed on areas within the Test and Trace portfolio of significant change. ToR and scope varied	UKG-DA engagement team will often organise targeted "breakout" meetings based on discussions in this call, e.g., finance, operations, policy, etc. UKG-DA team will update via email or call on any actions taken from the call.
UKG NHS Test and Trace Portfolio Delivery and Oversight Board	No. We are invited for awareness, no DA input.	Meeting used to gain early sight of UKG plans and subsequently raise issues where SG not being involved.	
"Front Door" Meetings (has had various names under different iterations, e.g., Portfolio Delivery Forum)	No.	This acts as a triage forum for programmes looking to enter the Test &Trace portfolio.	Offers SG early sight of upcoming UKG work.
Finance QUAD	No. For awareness in advance of Investment Board meeting later in week.	This is a heads up for BJTs that will go to Investment Board that week.	This is primarily a meeting between UKHSA, HMT and Cabinet Office, we often raise a question or two we may have at the end of each BJT discussion. But otherwise observe.

Meeting	Formal decisions at meeting?	Additional information	Additional informal processes?
Technologies Validation Group (soon turned into UKHSA Testing Supplies Governance)	No. Updates around testing technology in pipeline, validation and evaluation exercises, etc.	DAs feed into UKG process on validation new testing technologies, decisions made in respective DG administrations around applicability to own setting	
Design Authority Review Group (DAR) (UK) (eventually merged with Service Design Authority)	No	To receive early sight of new technologies procurement by UKG on behalf of DG administrations and potential new testing pathways to be onboarded.	
DA Weekly Operations Meeting and Policy meetings (soon turned into a combined "Operations, Policy and Strategy" meeting)	No. UKG DA team catalogued minutes, tracked actions, etc.	Opportunity for DG Administrations to raise issues with specific operational, policy and strategy leads. Leads of UKG teams use this to share updates on developing operations and/or policy and horizon scanning.	UKG-DA engagement team will engage via email and/or organise meetings based on discussions or issues raised from this call, usually to sort operational issues.
DSHC – MHRA Meeting A and Meeting B	No.	To hear updates on DHSC/UKHSA discussion with the MHRA and raise issues.	

Meeting	Formal decisions at meeting?	Additional information	Additional informal processes?
Testing Programme Investment Board	Yes, taken by senior UKHSA/UKG finance officials.	Member of the Investment Board to opt in and out of procurement and commercial decisions.	Minutes and outcomes of decisions tracked by Investment Board secretariat and outcomes shared with senior officials.
UKHSA sit-rep	No.	Cadence varied from daily, to 3 times a-week, to 2 times a-week. Daily performance report on capacity and demand – troubleshooting opportunity for various UKHSA team leads. DG administrations received invites to observe and listen.	Able to reach out to UKG DA engagement team or specific UKHSA leads for further information afterwards.
Testing Evaluation Board, and Quality Group (has had various names under different iterations)	No	Provides the latest information on evaluation of the Testing Programmes.	Feeds into SG Clinical Governance Group and CADI.
Testing Supply and Demand Management meeting(s)	Overall no, however small operational decisions are made at this call (e.g.,	DG administrations invited to attend for information and sometimes input.	

Meeting	Formal decisions at meeting?	Additional information	Additional informal processes?
	movement of LFD stock between warehouses, etc)	UKHSA demand modelling and operational colleagues receive modelling data and operational updates from DAs which inform decision-making around supply, etc.	
National Testing Programme Memorandum of Understanding (NTP MoU) meetings	Yes. UKHSA team engage with DG administrations regarding creation, revision, amendments for the NTP MoU.	The creation of the NTP MoU and the subsequent revisions and iterations of the past few years are done by UKHSA and DG administration officials. All of these have to ultimately be signed off by respective health ministers for approval.	

Co-operation and joint working with the UK Government on vaccinations

87. From January to June 2020, responsibility for all vaccinations policy sat within the Health Protection Division with oversight from the Director for Covid Public Health. From August 2020 to January 2021, Caroline Lamb was Delivery Director for the Vaccination Programme, working alongside the Director for Covid Public Health. In February 2021, due to the significant emerging policy, operational and delivery requirements, a separate Vaccinations Directorate was established with Stephen Gallagher as Director. The new Directorate had two Divisions, with Derek Grieve as Deputy Director of the Vaccines Operational Policy Division and Jamie MacDougall as Deputy Director of Vaccine Strategy Division.

88. The Directorate was merged back into the Directorate for Population Health in August 2022 as the Vaccinations Division.

89. In anticipation of a Covid-19 vaccination programme, a governance structure was set up in June 2020 by a Programme Management Team from National Services Scotland (NSS) commissioned by Scottish Government to support the Flu Vaccine and Covid-19 Vaccine (FVCV) programme which included:

- a **Programme Board** with governance and oversight of overall delivery and monitoring of key risks and milestones
- an **Executive Decision-Making Group** to allow for quick decision making on behalf of the wider Programme Board
- a **Delivery Group** to co-ordinate the delivery programme plan, chaired by the Programme Delivery Director and comprising the key delivery work-stream leads
- **thematic workstreams** to oversee activity on various policy and operational aspects of the programme
- **Clinical governance group** to ensure all decision making took account of clinical issues.

90. Alongside this, fortnightly performance management calls were also set up with Scottish Government and each Health board.

Four nations engagement and decision-making: Vaccination Programme

91. Over the period in question, the Scottish Government had regular meetings on a four nations basis to discuss the vaccination programme

Vaccine Supply

92. In April 2020 the UK Department for Business, Energy and Industrial Strategy (BEIS) created the UK Vaccines Taskforce (UKVTF) (now part of UK Health Security Agency) who carried out four nations procurement of Covid-19 vaccines to achieve the best value due to economies of scale. As such, the UKVTF obtained Covid-19 vaccines on behalf of the Scottish Ministers throughout the pandemic with Scotland receiving a population-proportionate share of any vaccines procured. The Scottish Government and FVCV worked closely with Public Health England (now the UK Health Security Agency) on vaccine supply, demand and logistics.

JCVI recommendations

93. The Directorate for Vaccine Policy and Strategy drew on information and expertise from a very broad range of sources throughout the time period specified, including, but not limited to: PHS; JCVI; the UK Government; the Medicines and Healthcare products Regulatory Agency (MHRA): UK CMOs; Deputy CMOs; Health boards; and the NHS.

94. As in the other UK nations, the Scottish Government adhered to guidance from the JCVI, although the vaccination programme was at times delivered at a different pace or delivery mechanism in Scotland to other devolved nations. In these instances, Scotland-specific public health messaging was necessary to ensure that the general public had the most up-to-date information.

95. The Scottish Government also took advice from wider groups, for example, when making decisions to offer vaccination to incoming international students' advice was provided by education policy, universities and colleges and informed by clinicians.

A chronology of decision making is provided below:

- 02 December 2020: JCVI published advice on the groups that should be prioritised for Covid-19 vaccination
- 08 December 2020: Scotland commences Covid-19 vaccination programme

- 30 December 2020: JCVI recommendation on the first and secondary priority groups for the Covid-19 vaccination programme
- 01 March 2021: Further considerations on phase 1 advice from the JCVI on homelessness, prison workers, prisoners and detained estates, and timing between vaccine doses
- 24 March 2021: JCVI recommendation that adult household contacts of adults with severe immunosuppression be offered Covid-19 vaccination
- 7 April 2021: JCVI recommendation on the use of Moderna Vaccine in the first phase of the programme for priority groups 1 to 9
- 7 April 2021: JCVI recommendation that under 30s be offered an alternative to the AstraZeneca Covid-19 vaccine
- 13 April 2021: JCVI recommendation that the offer of vaccination during phase 2 of the vaccination programme is age-based starting with the oldest adults first
- 16 April 2021: JCVI recommendation that pregnant women in the UK to be offered the Pfizer-BioNTech or Moderna vaccines
- 7 May 2021: JCVI recommendation that unvaccinated adults aged 30 to 39 years who are not in a clinical priority group are preferentially offered an alternative to the AstraZeneca Covid-19 vaccine
- 14 May 2021: JCVI recommendation to bring forward the second dose of vaccine from 12 to 8 weeks to mitigate the impact of the B1.617.2 variant of concern
- 19 July 2021: JCVI recommendation that children and young people at increased risk of serious Covid-19, or who live with an immunosuppressed person be offered the vaccine
- 04 August 2021: JCVI recommendation that 16 to 17-year-olds be offered a first dose and that children and young people aged 12 years and over who are household contacts of persons who are immunosuppressed should be offered 2 doses
- 01 September 2021: JCVI recommendation that a third primary dose be offered to individuals aged 12 years and over with severe immunosuppression
- 03 September 2021: JCVI advise against the universal offer of vaccination for those aged 12 to 17. Recommendation to expand the list of underlying health conditions that make those aged 12 to 15 eligible for a 2-dose vaccination schedule.
- 14 September 2021: JCVI recommendation that those vaccinated in Phase 1 of the vaccination programme be offered a third dose Covid-19 booster vaccine
- 20 September 2021: Scotland commences booster vaccination programme
- 15 November 2021: JCVI recommendation that all aged 16 to 17 be offered a 2nd dose

- 15 November 2021: JCVI recommendation that all adults aged 40 to 49 also be offered a booster vaccination
- 29 November 2021: JCVI recommendation that the booster vaccination be offered in order of descending age groups, with priority given to the vaccination of older adults and those in a Covid-19 at-risk group
- 16 December 2021: JCVI recommendation that pregnant women receive Covid-19 vaccination
- 22 December 2021: JCVI recommendation on the primary vaccination of those aged 5 to 11 and the booster vaccination of those aged 12 to 17
- 16 February 2022: JCVI recommend a non-urgent offer of vaccination to children aged 5 to 11 years of age who are not in a clinical risk group
- 21 February 2022: JCVI advises that a spring vaccine dose be offered to adults aged 75 years and over, residents in a care home for older adults and individuals aged 12 years and over who are immunosuppressed
- 07 March 2022: Scotland commences spring rollout of booster vaccinations.

96. Deployment plans were produced and published for each of the FVCV tranches within the scope of the inquiry covering operational planning details (CL3/0012 - INQ000147350, CL3/0013 - INQ000147413, CL3/0014 - INQ000147414).

97. Depending on the issues posed to the Vaccinations Divisions in the Scottish Government, those providing advice would change accordingly, but with the central medical guidance coming from clinicians, JCVI and the UK CMOs. For example, when making decisions to offer vaccination to incoming international students, advice was provided by education policy, universities and colleges and informed by clinicians.

Workforce and Military Aid to the Civil Authority (MACA) support

98. The Scottish Government worked closely with health boards to develop a flexible and responsive workforce in support of the vaccination programme. At peak points in earlier phases of our Covid-19 response, that workforce was capable of delivering up to 400,000 vaccines per week, nationally. This was achieved by recruiting and training significant numbers of Healthcare Support Worker vaccinators to complement the registered workforce, by redeploying staff from other lower priority services and supporting the participation of independent community healthcare professionals including GPs, pharmacists, dentists and optometrists. At times of peak delivery, due to

necessary short-notice programme acceleration, military support was procured via the MACA process.

99. More recently, the Scottish Government has worked with boards to generate a core vaccination workforce capable of delivering at a revised rate of 150,000 vaccines per week with scope to increase this towards 200,000 doses per week at points of high demand. This approach allowed us to make good progress with our most recent autumn/winter vaccination campaign.

Security

100. The FVCV programme included a security short life working group (SLWG) formed in December 2020 to coordinate security activities with stakeholders. This SLWG became a FVCV programme workstream in April 2021.

101. The security workstream managed the following:

- physical security procedures for vaccine storage, delivery and waste disposal
- personnel and protective security, via provision of advice, guidance, training and support
- monitoring of Covid-19 vaccine related mis and disinformation
- security minded communications; reminders, bulletins; and
- maintenance of a security incident log.

102. Throughout the specified period, the Scottish Security Workstream worked closely with the UK Department of Health and Social Care's UK Covid Vaccine Security Group (UKCVS) which was coordinating actions nationally in response to anti-vaccination activity at the UK level, recognising that such activity cuts across UK national and international boundaries.

Inclusion and equalities within the vaccination programme

103. The JCVI advised that implementation should involve flexibility in vaccine deployment at a local level with due attention to, amongst other things, mitigating health inequalities, such as might occur in relation to access to healthcare and ethnicity.

104. The national programme was clear from the start that the Covid-19 vaccination programme must be equitable and reach everyone in Scotland, both for individual health and collective community wellbeing. As such, a dedicated Vaccine Inclusion and Equalities Policy team was set up within the Directorate for Vaccine Policy and Strategy in February 2021.

105. A Vaccine Inclusion Steering Group was set up in March 2021 with membership from health boards, third sector, community and faith groups and met regularly to ensure a strong voice for equalities groups and representatives and provide greater leadership to inclusion and equalities as part of the vaccination programme. This group was an advisory group only and did not have any decision-making powers.

106. PHS began to include equalities data in their Covid-19 Statistical Reports from March 2021.

107. The collection of ethnicity data was introduced into the FVCV programme from November 2021.

Co-operation and joint working with the UK Government on international travel

108. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023 sets out a detailed explanation of the approach taken to manage the importation of the virus, including restrictions and guidance on international travel to and from places outside the Common Travel Area (CTA) (the UK, Ireland, the Channel Islands and the Isle of Man) and at times on travel within the CTA and Scotland.

109. The Scottish Government was responsible for decisions relating to restrictions and guidance on international travel to Scotland. Decisions were informed by data shared across the four nations and following four nations discussions at official and ministerial level.

110. The Scottish Government's view was that the fundamental purpose for border control and quarantine was the prevention of harm to individuals. The rationale was that the first duty of the state was, and is, to protect its domestic population, in this case from a virus that caused harm and death. Had Scotland allowed the unrestricted movement of individuals into Scotland from abroad, including from countries where the incidence of

the virus was higher than in Scotland, then the risk of new transmission chains of the virus entering the country would have increased, thereby putting the relatively fragile position with "R" in Scotland at risk of increasing.

111. It is worth noting that, the operationalisation of the measures was on a four nations basis. Whilst the legislative underpinning was devolved public health powers, Border Force, which controls entry into the UK, was responsible for implementation at the UK border given that immigration is a reserved matter. The controls were kept under regular review and revised including to change countries that were on relevant lists of each of the four nations, with Border Force enforcing the applicable rules at entry points into the UK.

Co-operation and joint working with the UK Government on Personal Protective Equipment (PPE)

112. There has been a great deal of collaborative work between the four nations on PPE issues, and the Strategic PPE Four Nations Board, chaired by the DHSC was established. The board's remit as of April 2021 was as follows:

- Provide oversight and assurance to Ministers of all four nations that the strategic aims of the UK-wide protocol to support collaboration on the sourcing and supply of PPE are being met
- Support the understanding of Covid-19 related PPE supply across the four nations through the sharing and consideration of country-level data and intelligence on PPE
- Facilitate UK-wide PPE demand modelling, sharing information on each country's stock positions, modelled requirements and planned procurement strategies to meet these requirements and coordinate strategies for meeting expected demand and planning of future strategies
- Consider the impact on supply and demand of any change in the use of PPE, including any changes to guidance on the use of PPE.

113. Information on the Strategic PPE Four Nations Board is being processed and will shortly be provided to the UK Covid-19 Inquiry.

Co-operation and joint working with the UK Government on Face Coverings

114. The diverging approaches to handling the pandemic between the Scottish and UK Governments also resulted in differences in public health messaging for Scotland specific issues. The messaging in Scotland was integrated into the wider SG approach on Covid-19 communications and engagement. This meant that the SG messaging had to be clear that requirements were still in place in Scotland to help ensure as much adherence as possible. This formed part of Scottish Government's FACT messaging on NPIs.

115. The Scottish Government's face covering policy was retained within legal requirements longer than UKG.

116. There was also a diverging approach in relation to the face covering exemption card scheme in that Scotland implemented a physical card whilst UKG offered a digital downloadable card. This was in place from inception of the Exemption Card Scheme, which was communicated alongside messaging to maximise the chances people were treated with kindness if they were unable to wear a face covering. (CL3/0015 - INQ000147349)

Information and evidence available to the HSCD regarding the nature and spread of Covid-19 in Scotland

117. The distinctions between diseases which are high consequence, emerging and novel, endemic and those that have pandemic potential (and go on to become pandemics in some cases) 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 with the other nations of the UK the 2011 Influenza Pandemic Strategy and that remains in place. That strategy 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. Bespoke administrative arrangements began to be made for Covid-19. Alongside High Consequence Infectious Diseases and the pandemic plan from 2011 there are now therefore specific arrangements made for the administration and policy response to Covid-19. With regard to High Consequence Infectious Diseases the key operational document is the Management of Public Health Incidents

guidance, first published in 2011, and last updated in 2020, and Scottish Government internal guidance on managing urgent and out of hours public health notifications.

Cooperation and joint working with the other Devolved Administrations

118. Officials from Scottish Government also met regularly with counterparts from other devolved administrations in relation to different subjects throughout the pandemic. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023 sets out information on intergovernmental liaison about the pandemic.

INFORMATION FLOW

Response Readiness and Delivery - Structural Change within DG HSC

119. A summary of structural and responsibility changes is provided below. Attached to each area of responsibility is a list of the decisions made during the period of January 2020 to April 2022.

- Directorate for Covid Health Response (DCHR) created in March 2020
- Directorate for PPE created in April 2020
- Directorate for Testing and Protect created in April 2020
- Directorate for Covid Public Health created in June 2020
- Directorate for Mental Health & Social Care created in June 2020
- Directorate for Community Health and Care stood down in June 2020 with responsibilities moved to the Directorate for Mental Health & Social Care and the Directorate for Primary Care
- Directorate for Primary Care created in July 2020
- Directorate for Outbreak Management created in July 2020
- Shielding Division, sitting in the Directorate for Population Health, created in July 2020 - re-named as Covid Highest Risk Division in June 2021
- Directorate for Vaccine Policy and Strategy created in February 2021
- Directorate for Mental Health created in December 2021.

Directorate for Covid Health Response (DCHR)

120. A Covid Response Team was set up by Scottish Government in the week commencing 16 March 2020 to focus on the emergency response for people who were considered most vulnerable to Covid-19. This was an expansion of the initial team and was in place by the end of week commencing 23 March 2020. The core team was drawn principally from Population Health and Children's and Families Directorate.

121. Many of the teams responsible for policy and operational oversight of pandemic response measures, including testing, and vaccinations were developed by the Health Protection Division. The main transition point was the creation of a Directorate for Covid Health Response (DCHR) on 16 March 2020, led by Richard Foggo and Donna Bell who became joint directors of the newly created DCHR until June 2020.

122. The DCHR was run as a single team with flexible resource, working seven days a week, on shift patterns.

123. On the 20 April 2020, the secretariat team within the new Directorate formed a Director General (DG) Health hub when SGoRR introduced eight "Group Hubs" for Covid-19 focussed work across SG. The Hub workstreams were reviewed and updated regularly to take account of the rapidly evolving situation. Subsequently, the DG Health hub along with the Briefing & Liaison team moved to the DG HSC office on the 1 June 2020 led by Michael Kellet as Deputy Director.

124. In May 2020, the DCHR was reviewed internally by its directors. This review was required to respond to the developing path of the pandemic and as well as the difficulties in sustaining a "matrix" approach. The review identified the need for greater clarity of relationship between DCHR functions, new functions that would be required (e.g., vaccinations) and existing functions in the Directorate for Population Health. It was also agreed that Covid Health Response functions should be overseen by a single Director, Richard Foggo with Donna Bell being asked to take on the Social Care and Mental Health functions.

Directorate for Covid Public Health

125. On 1 June 2020, Richard Foggo was then appointed as sole Director for Covid Public Health, with Donna Bell moving to become Director for Mental Wellbeing and Social Care. Following Richard Foggo's appointment, Elizabeth Sadler was then appointed interim Director for Directorate for Population Health between June – September 2020.

Michael Kellet took over as interim Director for Directorate for Population Health after September 2020.

126. The Directorate was initially made up of the following divisions, and headed up by the Deputy Directors listed:

- Covid Ready Society – Lesley Shepherd, with Elizabeth Sadler taking over in October 2020
- Covid Testing and Contact Tracing Policy Division – Niamh O'Connor, before being joined by John Nicholson as joint DD in July 2020
- Vaccinations (until February 2021 when it then moved to a new Directorate for Vaccinations) – Derek Grieve
- Community Surveillance – John Nicholson, before being replaced by Angus Macleod and Marion McCormack in July 2020. Andy Bracewell joined as joint DD in late 2020 with Marion McCormack moving to the Directorate for Vaccinations shortly after
- HSC Analytical Hub – Anita Morrison and Nicola Edge
- COVID-19 Data and Intelligence Forum - co-chaired by Scott Heald (PHS Head of Statistics) and Anita Morrison (Head of HSCA) set up around June 2020 to ensure effective coordination and coherence across the various Covid-19 data and intelligence streams that flow within the Scottish Government and between Scottish Government, PHS and National Services Scotland (NSS) as the main providers of Covid-19 data and analytical products and infrastructure solutions.

127. In Autumn 2020, Frank Strang and Lesley Sheppard moved on to new roles within Scottish Government, with Elizabeth Sadler also moving at that time from Population Health to take over the Covid Ready Society Division (CRS). Given the increasing workload she was joined by Marion McCormack as Deputy Director for the CRS in April 2021. The CRS Division led on Covid-19 protective behaviours of ventilation, face coverings, physical distancing, social mixing, coronavirus status certification and hygiene and ventilation.

128. The work of the Directorate for Covid Public Health continued to expand, and divisions were established to manage emerging policy strands of work in; Test, Trace Isolate, Transmission, Vaccines, Port Health, Legislation, Health Protection Scotland Liaison, Data, Excess Deaths and social distancing. Liaison with Health Public Scotland (HPS) continued but was also expanded to wider Scottish Government and

other sectors to ensure that an accurate and timely flow of public health advice was provided.

129. Also, the Directorate provided Deputy Director oversight for the Covid-19 Advisory Group, led by Daniel Kleinberg. Additional Deputy Director support was added in July 2020 with Angus Macleod, Marion McCormack and Frank Strang joining the Senior Management Team. Angus Macleod and Marion McCormack took over Community Surveillance Division, with John Nicholson and Niamh O'Connor leading Testing and Contact Tracing Policy Division. Frank Strang provided specific support – without a division – then moved to newly created care home pandemic division in Spring 2020 until moved to support the return of schools within the Higher Education/Further Education Directorate in summer/autumn 2020.

130. Although all teams had a role in delivery, their primary functions were policy development including formulating advice to ministers.

131. There were three primary functions of the Director for Covid Public Health from June 2020 that are relevant to how advice was formed to assist Ministerial decision making:

- Management responsibility for the dive Divisions (and other functions) in Covid Public Health, with line management responsibility for the Deputy Directors
- Coordinate liaison with both PHS and Directors of Public Health, which included the establishment of a "Daily Huddle" at which information was shared (this was not a decision-making forum). This was in addition to on-going daily liaison calls with PHS; and
- Lead policy advisor on public health, working closely with the senior clinicians (CMO, CNO and the NCD) to provide advice both on development of key Covid-19 strategies within DG HSC (e.g. test and protect, surveillance and response, vaccinations, certification etc) and on the health and social care contribution to the four harms decision making process (focused on harm 1 – direct Covid-19 harm). The Director for Covid Public Health would attend SGoRR meetings (both official and Ministerial), Four Harms meetings, topic specific deep dives with Ministers including the First Minister. Further information on the four harms is provided within the Module 2 Strategy and External Affairs statement, provided to the Inquiry on 23 June 2023.

132. A document showing the policy area and respective Deputy Directors is provided (CL3/0016 - INQ000147350).

133. The private sector engaged with the Directorate for Covid Public Health and provided information through meetings and discussions on a variety of subjects. Their views helped shape the policies on various issues, including in developing our delivery systems on:

- Certification
- Test and Protect
- Key Workers
- Testing
- Vaccines
- Shielding.

134. The Directorate for Covid Public Health disbanded in June 2022 when it re-merged with Directorate for Population Health. At that point, Director of Covid Public Health became Co-Director for Population Health with Director for Test and Protect Christine McLaughlin, and, until August 2022, Michael Kellet, who had been interim Director for Population Health for the period of 21 September 2020 until 18 August 2022.

Directorate for PPE

135. In April 2020, a new Directorate for PPE was established to provide strategic and coherent co-ordination in relation to all aspects of the provision of pandemic PPE in Scotland. The Directorate for PPE then became a Division of the Health Finance, Governance and Value Directorate in July 2020. It later became a Unit in Health Infrastructure, Investment and PPE Division in January 2021.

136. Paul Cackette, as Director of PPE, was responsible for delivering the Directorates remit to draw together five strands of corporate priorities:

- PPE for Health and Social Care staff and patients, with a focus on supply and distribution to frontline health and social care staff for Pandemic Preparedness Response (PPR) in accordance with professional advice
- PPE for non-health and social care users, supporting wider public service workforce supply and distribution of PPE in accordance with professional advice
- Co-ordinating Scotland's involvement in a four nations approach to PPE
- Working with Scottish companies on our own PPE manufacturing capacity, and

- Enhancing stakeholder consultation and communications both across Scottish Government and with wider partners including COSLA, Society of Local Authority Chief Executives and Senior Managers (SOLACE) and resilience partners.

Social Care PPE

137. Social care providers received PPE support during the pandemic through: (i) recouping pandemic-related PPE costs from Scottish Government funding; and (ii) accessing PPE free of charge from local and national PPE Hubs when supply routes failed. The PPE Hubs were supplied by NSS, with governance arrangements set out in a Memorandum of Understanding (MoU) which was co-signed by Scottish Government, COSLA, NSS, Health and Social Care Partnerships, Coalition of Care Providers Scotland (CCPS), Scottish Care and National Carer Organisations.

138. An Adult Social Care PPE Steering Group was also established, which was chaired by Scottish Government officials and whose membership consisted of the representatives from the organisations that co-signed the MoU. The Steering Group monitored the use of the PPE Hubs and levels of supply and demand, in addition to addressing ad hoc issues of concern raised by Steering Group members.

139. There were a number of extensions to the Memorandum of Understanding, the last being to 30 September 2022, and therefore outside of the scope of the dates specified in this request. Those within scope have been provided below:

- Social care PPE support arrangements Hubs and Support Centre (triage helpline) Memorandum of Understanding 13 May 2020, (CL3/0021 - INQ000147351)
- Support arrangements for PPE for the social care sector - October 2020, (CL3/0017 - INQ000147352)
- Memorandum of Understanding – Extension dated October 2020, (CL3/0018 - INQ000147342)
- Letter detailing support arrangements for PPE for the social care sector June 2021 (CL3/0022 - INQ000147353)
- Support arrangements for PPE for the social care sector – September 2021, (CL3/0019 - INQ000147354)
- Memorandum of Understanding – Extension dated Sept 2021 (v5) (CL3/0020 - INQ000147343)

- Memorandum of Understanding – Extension dated March 2022 (v6) (CL3/0023 - INQ000147355)

PPE Decision making

140. All significant decisions taken regarding PPE within the PPE Directorate / Division were taken by the Strategy and Governance Board. All papers and agendas will shortly be provided to the UK Covid-19 Inquiry. All decisions made by the PPE Strategy and Governance Board were recorded in the minutes which were published on the Scottish Government website.

141. Stakeholders were reporting that some organisations carrying out essential public services were struggling to source PPE. In some sectors this was acute, in particular, funeral directors. As many of these were small organisations, it was decided to bring in a large third-party supplier (Lyreco) to purchase PPE as they had more reliable supply chains that could secure PPE at lower prices than the smaller organisations. The contract was established by the Scottish Government. This was a paid for service, from which organisations bought PPE.

142. The Lyreco framework was set up on an exceptional basis to respond to an unprecedented need and was awarded under a Non-Competitive Action (NCA). The contract was awarded on 26 May 2020 and ran up to, and including, 31 October 2021. There was a significant drop in orders from the beginning of 2021, which suggested normal business supply routes and market prices had stabilised. This correlated with wider understanding of the global market and the improved stability since the beginning of the pandemic, and therefore provided an acceptable justification to end the contract.

143. The Scottish Government worked throughout the pandemic to ensure adequate PPE supply for Scotland. This resulted in PPE stock that was unlikely to be used in health and social care settings as the pandemic progressed or for which continued retention would not benefit the public purse. This PPE was directed to other areas of the public sector, donated internationally or recycled to provide the best value for money for the taxpayer and minimise environmental impact. A total of 25.7 million items of our PPE was shipped internationally with a total value of £11.2 million. In addition to the value of the stock itself, the Scottish Government contributed £250k from our existing International Development Fund to the cost of shipping.

144. The Cabinet Secretary's agreement was sought on the terms of the four nations PPE collaborative protocol. Following work at official level, Scottish Government and NSS officials were content that the new protocol would help to ensure Scotland's needs were met, and did not interfere with Scotland's ability to act independently when that is the most appropriate response

145. A Future Pandemic PPE supply programme was established to ensure lessons were embedded.

Directorate for Test and Protect

146. On 6 April 2020, Annabel Turpie was appointed Director of Testing and Ian Donaldson was the Deputy Director until 29 May 2020, leading on the Testing capacity across Scotland to support a Test, Track, Isolate approach to managing Covid-19. The Directorate for Testing took on policy and operational oversight responsibility from DCHR from 6 April 2020 until 29 May 2020. Policy responsibility for test and protect was transferred back to Directorate for Covid Public Health in June 2020, but operational oversight remained separate, with Jill Young and Christine McLaughlin were appointed co-Directors of Test and Protect, in June 2020. Christine joined the Directorate for Covid Public Health in June 2021 to share duties with Richard Foggo.

147. Caroline Lamb was Delivery Director for **Contact** Tracing and Isolation from May 2020 to August 2020.

148. Prior to September 2020, key decisions on social care workforce testing were led by the Testing Division and the CNO Directorate in the Scottish Government with input from the Adult Social Care Pandemic Response Division. From September 2020, the Pandemic Response Division took the lead on social care workforce testing. Advice for care home resident testing was led by PHS.

149. Key relevant documents have been provided at: CL3/0024 - INQ000147357, CL3/0025 - INQ000147356, CL3/0026 - INQ000147428, CL3/0027 - INQ000147429, CL3/0028 - INQ000147363, CL3/0029 - INQ000147364, CL3/0030 - INQ000147365, CL3/0031 - INQ000147366, CL3/0032 - INQ000147358, CL3/0033 - INQ000147359, CL3/0034 - INQ000147360, CL3/0035 - INQ000147361, CL3/0036 - INQ000147362, CL3/0037 - INQ000147367, CL3/0038 - INQ000147368, CL3/0039 - INQ000147369,

CL3/0043 - INQ000147460, CL3/0044 - INQ000147371, CL3/0045 - INQ000147372, CL3/0046 - INQ000147373.

Directorate for Outbreak Management

150. Paul Cackette was appointed Director for Outbreak Management July 2020, with Penelope Cooper taking over in November 2020 when Paul Cackette retired from the Scottish Government. This Directorate was made up of three teams covering Policy, Strategy and Response. The Outbreak Management Response Team function transferred from the Directorate for Outbreak Management to Covid Public Health in October 2020 and Andy Bracewell, Head of Outbreak Management Response joined Angus Macleod and Marion McCormack as joint Deputy Directors for Community Surveillance. The Directorate for Outbreak Management became the Directorate for Covid Co-ordination around 30 April 2021. These functions sat in DG Strategy and External Affairs (not DG HSC) but shared some staff and worked particularly closely on certain functions.

Shielding Division

151. Further to the changes outlined, the Shielding Programme was established in March 2020 to identify, protect, support and advise people considered to be at highest risk of severe illness or death should they contract Covid-19, with Michael Chalmers as the initial Director. A Shielding Division was formally established, sitting in the Directorate for Population Health from July 2020 onwards. The Division was led by Orlando Heijmer-Mason as Deputy Director. The Division was re-named the Covid Highest Risk Division in June 2021. This followed a decision on 28 June 2021 to rename the Shielding List of approximately 185,000 people, the 'Highest Risk List', given we were no longer asking people to shield, and the name was causing some confusion regarding Scottish Government policy intent. The Division eventually merged into the Covid Ready Society Division in August 2022, following the closure of the Highest Risk List in Scotland in May 2022, and after the Covid Public Health Directorate merged with the Directorate for Population Health.

152. The Shielding Policy team directly provided information to ministers including regarding return to work and risk assessment, and NPIs, such as face coverings, including for HSC workers, considered to be at highest risk from Covid-19 who were on

the Shielding/Highest Risk list. Clinical Leads Advisory Group (CLAGS) members fed into the Shielding policy team via the CLAGS meetings and secretariat.

Directorate for Vaccine Policy and Strategy

153. From August 2020 to January 2021, Caroline Lamb was also Delivery Director for the Flu and Covid Vaccination Programmes. The Directorate for Vaccine Policy and Strategy was established on 15 February 2021, headed up by Stephen Gallagher, in the position on Director.

154. The new Directorate for Vaccine Policy and Strategy remained unchanged until 30 April 2022, before being merged back into the Directorate for Population Health in August 2022 as the Vaccinations Division. Please refer to paragraph 87.

Directorate for Health Workforce

155. Health Workforce was an established Directorate prior to the pandemic. However, following Gillian Russell's appointment as Director on 16 March 2020, existing staff resource pivoted to have an almost exclusive focus on supporting the response to the pandemic.

156. Work within existing divisions was reprioritised and a Health Workforce Directorate Hub was created to deal with the significant increase in correspondence and provide central coordination for briefings and requests. A Wellbeing and Leadership Division was established in April 2020, recognising the need for nationally led services to provide wellbeing support for staff across Health and Social Care.

157. The Health Workforce Directorate has a significant range of functions to support the NHS workforce. During the late spring and summer of 2020, the Directorate was restructured into 3 core workforce divisions – Workforce Planning and Development; Workforce Pay, Practice and Partnership; and Workforce Leadership, Culture and Wellbeing. In responding to the pandemic Health Workforce was responsible for:

- Delivery of the Test and Protect workforce;
- Delivery of the Vaccinations workforce;
- Innovation around Wellbeing support;

- Amendments to NHS Terms & Conditions;
- Partnership relations with unions and professional bodies and NHS Employers;
- A range of employee / employer Covid guidance for the NHS;
- Supporting Health boards in relation to the redeployment of staff to essential clinical roles;
- Supporting additional recruitment including of staff returning to the service;
- Working with NHS NES and higher education partners to address key strategic issues and risks around healthcare student placements;
- Supporting the deployment of students into the workforce.

158. The Director of Health Workforce also facilitated engagement between Malcolm Wright, the then DGHSC, and the military with a view to bringing in expertise on strategic command capability. The military provided support to the DG over a period of months to enable optimum pandemic response and capability building, including improving resilience and creating effective challenge to internal thinking and delivery proposals at pace and scale.

159. A chronology of the key decisions on which Health Workforce was the lead directorate is provided (CL3/0047 - INQ000147408).

160. Changes to the senior leadership of the Directorate are provided below:
- Shirley Rogers, Director of Health Workforce left post on 13 March 2020. Gillian Russell took over the post of Director of Health Workforce on 16 March 2020 and is still in post.
- Sean Neill, Deputy Director for Health Workforce left his post in March 2020 and returned as the Interim Director of Health Workforce (new post) from April 2020 until March 2021. This was an additional post in recognition of the scale of work for the existing Director.
- Stephen Lea-Ross was promoted to Deputy Director of Health Workforce in March 2020 and is still in post.
- David Miller was appointed as Chief People Officer for the Office of the Chief Executive NHS Scotland in April 2020. David returned to work for NHS Scotland in December 2022.
- Laura Zeballos was promoted to Deputy Director of Pay, Practice & Partnership (new post) in May 2020. Laura is still in post.

- Victoria Bowman, joined as Deputy Director of Pay, Practice & Partnership on 17 August 2020. The post is job share with Laura Zeballos. Victoria took a career break on 31 January 2023.
- Catherine McMeeken joined as Deputy Director of Wellbeing, Leadership and Talent Management in October 2020 and left her post in April 2023.

Directorate for the Chief Operating Officer

161. The Directorate for the Chief Operating Officer (DCOO), NHS Scotland (formerly the Directorate for Performance and Delivery (DPAD)) was an established Directorate before the pandemic. The Directorate seeks to achieve the best health and care outcomes for people by supporting NHS Scotland to deliver the best possible performance.

162. The Director leading DCOO at the start of the pandemic was John Connaghan (designation being Director for Performance & Delivery). He was both Director for Performance and Delivery and Interim Chief Executive of NHS Scotland (between April and December 2021). He was designated as Chief Operating Officer (COO), NHS Scotland in January 2021 and remained in this post until June 2021 when John Burns took over and remains in post.

163. The three key policy divisions involved in the response to the Covid-19 pandemic were:
- the Health Emergency Preparedness, Resilience and Response Division (Health EPRR and previously Health Resilience Unit)
- the Performance and Delivery Division, and
- the Health Planning and Sponsorship Division.

164. Health EPRR led on:
- the initial stages of supply and procurement of PPE to NHS Scotland including liaising with the other UK Nations (until the Scottish Government PPE Unit was established in April 2020)
- support for the Ministerial Group chaired by Ivan McKee, then Minister for Trade, Investment and Innovation, established to lead on the procurement and supply of medical devices and equipment, alongside NSS and other SG directorates

- national pre-Covid-19 pandemic stockpiles of PPE, other consumables, antivirals and antibiotics - including working with other UK nations, and
- supporting NHS Scotland in exercising pre-pandemic working with key stakeholders.

165. From a Health EPRR division perspective, there were various PPE issues during early 2020 including procurement decisions, developing principles of stock sharing with other UK nations, delegating use of the pandemic stockpiles to the NHS, providing spending authority for procurement and surveying of NHS boards on usage of FFP3. Supporting documents on this are provided: 28 March 2020 – Submission on FFP3 Procurement, (CL3/0048 - INQ000147461, CL3/0049 - INQ000147374)

166. The Performance and Delivery Division led on:

- Testing capacity and demand
- Actions to increase the number of ventilators and subsequently the number of ICU beds available across NHS Scotland during the initial months of the pandemic in 2020
- Utilisation of the private sector to increase capacity
- De-mobilisation decision – pause in elective care; Development and publication of the framework for the clinical prioritisation of elective care to support boards take decisions on how they prioritise patients
- Re-mobilisation planning and decision to restart elective services
- Delivery of the NHS Recovery Plan (CL3/0050 - INQ000147430)
- On-going monitoring and reporting on NHS Board performance for both planned and urgent/unscheduled care
- Delivery of Redesign of Urgent Care including actions to control attendances to A&E
- Engagement with Public Health Scotland, in particular around data and intelligence on the likely trajectory of the on-going spread of virus.

167. Health Planning and Sponsorship Division led on:

- Providing a co-ordinated approach to evidence and information on capacity and pressures across health and social care
- Remobilise, Recover Re-design: the Framework for NHS Scotland, (CL3/0051 - INQ000147375)

- The Mobilisation Recovery Group (MRG) which was established as an advisory group to Ministers in support of the above Framework;
- operational Planning (including de and re-mobilisation planning) policy for NHS Boards
- increasing intensive care (ICU) capacity on a permanent basis - commissioned jointly by the COO NHS Scotland, CMO, and CNO
- NHS acute capacity indicator(s) used to determine the geographical 'Levels' approach to suppressing the virus
- NHS Board Performance Escalation Framework (with any decision to escalate a Board to the highest stage taken by the Cabinet Secretary with advice from the HSCMB)
- NHS Board Annual and Mid-Year Reviews
- National Planning and Performance Oversight Group (NPPOG).

168. From a Planning and Sponsorship division perspective, a timeline of decisions taken is produced and is provided (CL3/0052 - INQ000147376)

169. The Health Planning and Sponsorship Division also held the following meetings:

- Mobilisation Recovery Group (MRG) Meetings. This advisory group was established under the Remobilise, Recover and Redesign: National Framework for Scotland. It provided input to decisions on resuming and supporting service provision but was not itself a decision-making group. All meeting notes and dates are being processed and will be shortly provided to the UK Covid-19 Inquiry. (CL3/0058 - INQ000147416)

- ICU Uplift SLWG Meetings. The ICU uplift SLWG made recommendations to the COO, CMO and CNO, and then to the Cabinet Secretary. The Cabinet Secretary took the final decision to implement an additional 30 level 3 intensive care beds (for patients requiring highest levels of clinical support) across Scotland on a permanent basis. The SLWG did not have decision making authority. The SLWG was reconvened in November/December 2021 with a reduced membership to make recommendations on changes to the ICU surge escalation policy.

- National Planning and Performance Oversight Group (NPPOG) - the purpose of the Group is to provide oversight of planning, performance and escalation issues within the context of Scottish Government sponsorship arrangements. The Group informs,

advises and provides assurance to the HSCMB on issues of planning, prioritisation, performance and risks impacting on Health boards and their delivery partners, and act as a forum for managing exceptions and change control.

- Health EPRR and Public Health Divisions were invited and were part of some of the Four Nations Ministers health department meetings. Supporting documents around this are exhibited. (CL3/0053 - INQ000147378, CL3/0054 - INQ000147379, CL3/0055 - INQ000147380, CL3/0059 - INQ000147377)

- Daily direct engagement between COO and Ministers - Ministerial Private Office would set agenda and communicate key decisions from these meetings. Where Health EPPR were involved, there may have been a pre-call prior to the actual meeting to review agenda and consider Scotland position e.g., on PPE issues.

Directorate for Social Care and National Care Service Development

170. The Scottish Government sets out the overall strategic framework and legislative basis for the delivery of adult social care while local authorities have a statutory responsibility to provide the services.

171. The Public Bodies (Joint Working) (Scotland) Act 2014 requires local authorities and NHS boards to work together through Integration Authorities to plan, commission and deliver services. In the majority of cases, this is achieved through an Integration Joint Board (IJB). IJBs are responsible for the planning of adult social care services, as well as some health services and other functions. These services were previously managed separately by NHS boards and local authorities and are now delegated to IJBs. Although responsibilities may be delegated, local authorities and NHS boards remain accountable for the statutory duties conferred on them by legislation. Local authorities are accountable to the electorate, NHS boards are accountable to Scottish Ministers and the Scottish Parliament, and ultimately the electorate. IJBs are jointly accountable to local authorities and NHS boards through their voting membership and via reporting to the public. As distinct legal entities, IJBs are corporately responsible and accountable for complying with all relevant law when carrying out their services. In Scotland, adult social care is delivered by a wide range of partners including the public, independent and third sectors. There are also a number of regulatory bodies with an interest in the health and social care sectors that will scrutinise the operations of IJBs.

172. Currently, Donna Bell is Director for Social Care and National Care Service Directorate. Previously, social care formed part of the Directorate for Mental Health and Social Care under Donna Bell, and prior to that, part of the Community Health and Care Directorate under Elinor Mitchell. Elinor was Director at the outset of the pandemic, with the Directorate including two social care divisions, in addition to primary and community healthcare, as set out below:

- Adult Social Care Division – led by Deputy Director, Jamie Macdougall, and
- Health and Social Care Integration Division – led by Deputy Director, Alison Taylor.

173. Adult Social Care Division covered adult social care policy, and the reform programme, social care workforce and fair work, Care Inspectorate sponsorship, Adult Support and Protection, Unpaid Carers policy, Independent Living Fund, Survivors in Care, Assisted Communications and Sensory Impairment.

Pandemic Response Divisions

174. At the start of the pandemic, both the Health and Social Care Integration and Adult Social Care Divisions came together to support pandemic response for the social care sector. The Care Homes Pandemic Division was then subsequently formed under Frank Strang, and supported by professional adviser, David Williams. This Division oversaw the provision of support to the care home sector during the early stages of the pandemic. The remit of the Division was then widened to include provision of support across all of social care and was renamed the Adult Social Care - Responding to the Pandemic Division, led by Deputy Director Anna Kynaston and then Jennifer Veitch.

Revised Directorate and Divisional structures

175. From June 2020, the Directorate for Mental Health and Social Care was established, and, in October 2020, the Directorate restructured to support recovery and renewal whilst continuing to support pandemic response. The revised structure had five social care divisions as below and two mental health divisions:

- Responding to the Pandemic - supporting key areas such as Covid-19 testing, vaccination, PPE and practice guidance across adult social care provision – Deputy Director, Anna Kynaston (replacing Frank Strang)

- Remobilisation, Recovery and Reform – Deputy Director, Kate Hall
- Policy and Delivery- Deputy Director, Gillian Barclay
- Governance, Evidence and Finance – Deputy Director, Iain MacAllister
- Support for the Independent Review of Adult Social Care – Deputy Director, Alison Taylor.

176. These divisions were revised or augmented in September 2021 to a new structure as follows:

- Adult Social Care Workforce and Fair Work Division – led by Deputy Director, Ian Turner. Responsible for supporting and developing policies for the social care workforce including responsibility for workforce planning and development, recruitment, leadership, skills and training across the adult social care workforce, including personal assistants
- Improving Social Care Quality Standards and Delivery Division – led by Deputy Director, Simon Cuthbert-Kerr. Responsible for adult social care policy including leading on care at home, unpaid carers, care home charging policy, Self-Directed Support, assisted communications and GIRFE (Getting It Right For Everyone)
- Regulation Improvement and Integration Support Division - led by Deputy Director, Iain MacAllister. Responsible for the sponsorship of the Care Inspectorate and the Independent Living Fund Scotland; and for Adult Support and Protection, financial support for social care providers (sustainability payments), cross-cutting work to strengthen regulation and improvement in social care
- Resilience and Pressure Unit - led by Deputy Director, Gillian Barclay. Responsible for responding to the significant challenges being placed on operational delivery of social care in Scotland
- National Care Service Development – Deputy Director, Anna Kynaston. Responsible for the development of the National Care Service
- Adult Social Care Pandemic Response – Deputy Director, Jennifer Veitch. Responsible for engagement with the adult social care sector on pandemic response and guidance on areas such as face masks, testing and care home visiting and embedding good practice and improvement based on learning from the pandemic and building foundations for the recovery of the sector.

177. In December 2021, a separate Directorate for Mental Health was established, led by interim Director Hugh McAloon. All social care divisions subsequently formed part of a

new Social Care and National Care Service Development Directorate, led by Donna Bell.

178. Now, the Social Care and National Care Service Development Directorate leads on Social Care policy with a focus on supporting people to lead independent lives in their own communities, and creation of a National Care Service, a cross government priority, with the aim to transform our community health and social care support and services, empowering people to thrive, with human rights at the core.

179. Within the Directorate above, a Responding to the Pandemic Division was created to combat the issues created by the pandemic across the totality of social care. This Division has since been renamed to Adult Social Care Oversight and Assurance Support with Jennifer Veitch as the Deputy Director. This division has supported, among other things, engagement with the adult social care sector on pandemic response and guidance on areas such as face masks and testing and care home visiting.

The Healthcare Quality and Improvement (HQI) Directorate

180. Healthcare Quality and Improvement was an established Directorate prior to the pandemic. The Directorate is led by Linda Pollock, Director and supported by the NCD, Professor Jason Leitch. The Directorate has overall responsibility for policy on safety in healthcare, person-centred care, healthcare quality, palliative and end of life care, health policy for armed forces and veterans in Scotland and clinical priorities such as cancer, heart disease, respiratory disease, neurological disease, rare diseases and many other clinical conditions. In addition, the Directorate also covers the development of policy to support improvement within NHS Scotland: the Office of the Chief Designer, NHS Scotland communications and the Leading Improvement team, among others.

181. From January 2020 to April 2022, the HQI Directorate also had overall responsibility for the following:

- hospital visiting guidance - HQI led on the development of detailed guidance and principles to support Scottish Health boards to manage hospital visiting during the pandemic. This was done in partnership with other Scottish Government teams whose policy responsibility included hospital services, principally mental health and maternity. The guidance was formulated in response to Infection Prevention Control

(IPC) and wider Public Health guidance, feedback from the visiting reactivation forum (VRF), senior clinical advice and statutory regulations imposed between March 2020 and January 2022. As these guidelines and statutes changed throughout the pandemic, the hospital visiting guidance was adapted accordingly

- coordination and responding to correspondence from members of the public believing they were at the highest risk from Covid-19 but had not received a shielding letter
- development of supporting material for specific clinical conditions such as rare disease, neurological conditions, and cancer (not including shielding advice); including provision of additional support for highest risk
- facilitation and secretariat function for Clinical Leadership Advisory Group
- development and publication of the Respiratory Care Action Plan (CL3/0060 - INQ000147417) (considering the impact of the pandemic on respiratory care)
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Anticipatory Care Planning (ACP) - HQI Directorate took over responsibility for DNACPR in November 2020 from Health and Social Care Integration Division within the Community Health and Social Care Directorate, as part of the wider Palliative and End of Life Care Policy. There was a collaborative approach to co-ordinating a number of letters and guidance notes primarily for General Practices (GPs) and social care in residential and nursing homes, as well as for those who were identified as being at higher risk and highest risk (shielding). Letter and guidance notes covered a range of issues including DNACPR and ACP. Specific working groups or decision-making bodies in relation to DNACPR were not established, but the team contributed directly to joint correspondence and guidance. Some close work was also involved with the-then Chair of the Royal College of GPs (RCGP) and Scottish GP Committee (BMA), as well as HIS
- Anticipatory Care Planning - HQI Directorate had responsibility for the existing policy on Anticipatory Care Planning. The team worked with NHS24 and HIS to update the NHS Inform page on Anticipatory Care Planning (CL3/0061 - INQ000147418) and develop a video with HIS to support the public to understand exactly what was involved in an ACP conversation. There was an ACP Strategic Group led by HIS with SG involvement
- Hospices – the HQI worked with Scottish Hospices through the Scottish Hospices Leadership Group to establish financial support required by hospices due to the impact of Covid-19. This included £10m in June 2020 and a further £16.9m in March 2021

- Cancer - The cancer policy team and cancer advisory groups within DG HSC provided advice to the CMO and Ministers regarding new practice and guidance. In the immediacy of the pandemic, the Cancer Treatment Response Group was established. In June 2020, a new oversight committee, the National Cancer Recovery Group (NCRG) was established, which had oversight of the National Cancer Treatment Group (NCTG), national cancer data group and the national cancer quality steering group. NCTG provided oversight of the established Systemic Anti-Cancer Therapy (SACT)/Radiotherapy (RT) Subgroup and the Covid-19 National Cancer Medicines Advisory Group. Following a review completed by NHS National Services Division (NSD) in December 2020 and the publication of the National Cancer Plan that month, a new governance model was implemented and is largely still in place to date. The NCRG provided oversight for the following established subgroups which has a role in the pandemic response: SACT Programme Board, Surgery Programme Board (since discontinued), RT Programme Board, and the Cancer data programme board. The Scottish Government held regular meetings of the NCRG (Cancer Treatment Response Group – its predecessor), and its subgroups, which discussed various matters. These meetings were not attended by Ministers but were attended by policy officials across Government (cancer, diagnostics, vaccinations, screening, etc). In addition, clinical leads from across cancer services were represented on the group and regional cancer network managers were represented. The groups approved various pieces of clinical guidance for use in cancer services in Scotland. This included the development and dissemination of the cancer surgical prioritisation framework (based on existing guidance by the Federation of Surgical Associations (FSSA), the Systemic Anti-Cancer Therapy (SACT) prioritisation framework and managing SACT RT for Covid-19 positive cancer patients. This was based on clinical advice from governance groups, and wider clinical networks. A full list of their minutes is provided
- Independent Healthcare – provided advice, via HIS, to independent services regarding services they were able to provide throughout Covid-19; and testing of staff. Also provided briefing and advice to Scottish Ministers regarding services able to be delivered during Covid-19 and HIS independent healthcare budget. Exchanges with Chief Dental Officer, finance, other policy areas and SGLD were carried out by the Openness and Learning Team.
- Long Covid-19 – Briefing and advice to Scottish Ministers regarding the establishment of Scotland's long Covid-19 service and of a strategic network to have oversight of the service

Chief Medical Officer (CMO) Directorate

182. The directorate works with Ministers and stakeholders to lead medical and public health professionals and provide clinical advice on professional standards and guidelines which:

- encourage sport and physical activity
- provide effective health protection services, disease surveillance and outbreak management
- invest in medical research, particularly related to the NHS and its services.

183. In April 2020 the CMO directorate published a Covid-19 Palliative Care Toolkit to provide health board planners with options that could be adapted and utilised locally in their response to COVID-19. The toolkit is now archived on the National Records of Scotland website.

184. Further information is provided in the Module 2A Corporate statement provided in the corporate statement covering the expert health entities provided to the Inquiry on 23 June 2023.

Chief Nursing Officer (CNO) Directorate

185. The CNO is responsible at national level for all matters that relate to the professional leadership of nurses, midwives, Allied Health professionals (NMAHP) and Healthcare Scientists (HCS) across Scotland. Given the impact of the NMAHP/HCS profession on improving health and delivering world class safe and effective healthcare, it supports the achievement of the best health and care outcomes by providing transformational leadership of the professions.

186. This directorate pro-actively informs the 'future of state' in relation to health and social care across Scotland and in turn improve outcomes for the people of Scotland through the contribution that our policy and professional advisors make to this wider agenda. Both internally and externally, the Chief Nursing Officer Directorate provide expert clinical and policy advice in relation to all aspects of NMAHP/HCS, Regulation of Healthcare Professionals, and Healthcare Associated Infection/Antimicrobial Resistance.

187. The Directorate is responsible for:

- providing policy and professional advice to Ministers on matters relating to the education and workforce development of the professions for which CNOD have leadership, Healthcare Associated Infection/Antimicrobial Resistance, Professional Healthcare Regulation and also wider strategic and policy aims for the various professions within our remit
- overseeing the current student nurse, midwife and paramedic intake on an annual basis
- maintaining visible professional leadership and providing quality advice within Government and within the wider health and social care system in Scotland and the UK on issues relating to nursing, midwifery, allied health professions and health-care science
- the successful implementation of the Health and Care (Staffing) (Scotland) Act 2019, which is being delivered in partnership with the Healthcare Staffing Programme operated by HIS and the Safe Staffing Programme operated by the Care Inspectorate. The Act will support Scotland's health boards and care services to have the right number of staff in the right place and is the only comprehensive safe staffing law anywhere in the UK. The Act was paused during Covid-19
- leading on all professional and policy aspects of healthcare-associated infection policy and antimicrobial resistance
- leading on Professional Healthcare Regulation including matters relating to Scotland's interests in overarching UK-wide reform of professional healthcare regulation.

Primary Care Directorate

188. The Primary Care Directorate was formed in July 2020. The Directorate included Dentistry Division from the Directorate for Population Health and GP Division from the Directorate ofCommunity Health and Care, and also took over formal National Board Sponsorship arrangements for NHS 24 and SAS, inclusive of Primary Care Out of Hours Services. Aidan Grisewood was appointed as the interim Director of Primary Care from its inception and was in post until June 2021, after which he was replaced by Tim McDonnell.

189. Tom Ferris, as Chief Dental Officer, had responsibility for Dentistry Division. Naureen Ahmad, as Deputy Director for General Practice, had responsibility for General Practice Policy. Heather Campbell was the Deputy Director with responsibility for primary care out of hours services and NHS 24 and SAS Sponsorship. Heather Campbell was in post until January 2022.

190. The Directorate also had approximately 15 professional advisers from across dentistry, optometry and general practice who provided support to the policy teams. They came from clinical and management professional backgrounds, working at senior levels in their organisations.

191. Primary healthcare is and remains the first point of contact for people seeking treatment, medical advice, prescriptions, or referrals to specialist care. At least 90% of all health contacts take place in primary care settings. Whilst Primary Care is often associated with GP services, for governance and delivery purposes, it also consists of dentists and dental nurses, pharmacists and pharmacy technicians, optometrists, dispensing opticians, and audiologists. Primary Ccre also plays an essential role in supporting the provision of urgent and unscheduled care both in hours and out of hours, including working with NHS 24 and SAS.

192. The vast majority of Primary Care services are delivered by Independent Contractors (ICs). Over the period January 2020-April 2022, Primary Care Directorate – and its predecessor divisions – oversaw the implementation of policy relating to IC contracts and provided funding to deliver services in relation to general practice, dentistry and optometry. It also oversaw wider policy around Primary Care services that were outwith core contractual terms and conditions. Clinical governance was not the responsibility of Primary Care Directorate and as noted in the sections on General Practice and Dentistry below, it is the responsibility of health boards and HSCPs. Changes to clinical practice did not sit within Primary Care Directorate and remained the responsibility of the CMO.

193. In terms of urgent Primary Care, Out of Hours services were provided by health boards; the Primary Care Directorate oversaw funding and monitored delivery of this service as part of broader NHS performance structures that reported to the Chief Operating Officer. NHS 24 and SAS are national health boards and were part of the central governance structures for all health boards. Primary Care Directorate continued to provide sponsorship to both SAS and NHS 24 during Covid-19

194. Primary Care Directorate utilised a number of governance groups and organisations to interact and connect with the independent contractor and broader national Primary Care community, including Chief Officers Recovery and Remobilisation Group, National Services Scotland PPE Modelling Group, British Medical Association (BMA) / RCGPs / SG Trilateral, BMA / SG Bilateral, Chief Officer / SG Bilateral, Directors of Dentistry's Group, Primary Care Leads, Short-life sub-group on Primary and Community Health Care (PCSG)

195. The Primary Medical Services (Scotland) Act 2004 amended the National Health Service (Scotland) Act 1978, by placing a duty on health boards to provide or secure "primary medical services" for their populations. Health boards can contract with GPs to deliver services and/or run their own.

196. The majority of general practices in Scotland are run by GPs as independent contractors. The GP partners contract with the health board to deliver general medical services and in turn they receive funding based on the size of their patient list and other factors such as demographics and rurality to deliver services. These services are delivered via the GP partner(s) who lead a multi-disciplinary team of practice employed and, increasingly, health board employed staff. In practices run by health boards, all staff are salaried. This GP governance and delivery arrangement remained in place through the pandemic.

197. The contract, colloquially known as the “GP contract”, focusses on delivery of medical services to patients and related terms and conditions. Where a practice was run by a GP partner as an independent contractor, they did so under a 17C Primary Medical Services agreement or 17J General Medical Services contract. Health board run practices operated under section 2C of the 1978 National Health Service (Scotland) Act and are and remain colloquially referred to as 2C.

198. The terms and conditions of the GP contract were and remain negotiated nationally between the Scottish Government and the BMA. Wider policy around GP services that may not sit in the strictly contractual terms and conditions space is also negotiated and agreed in this bilateral space.

199. Day to day contract management took place at health board and HSCP level through Primary Care teams who provide support, advice, development of services, and clinical governance to general practice.

200. Under section 1 of the Public Bodies (Joint Working) 2014 Act, a set of health board functions must be delegated to Integrated Joint Boards (IJBs). IJBs took steps to plan and commission these functions. Consequently, a number of key functions were delegated to IJBs for HSCPs to deliver, including primary care and the development of multi-disciplinary teams to support general practice as part of Phase One of the 2018 GP Contract. GP partner(s) at a local level led a multi-disciplinary teams comprising practice employed and, increasingly, health board employed staff under the framework of a national contractual arrangement.

201. Section 25 of the NHS (Scotland) Act 1978 provides for NHS Boards to make arrangements with independent dental contractors for the provision of General Dental Services.

202. Independent dental contractors were required to meet Terms of Service as set out in Schedule I (Part II) of the NHS (General Dental Services) (Scotland) Regulations 2010. The terms of service make requirements on independent contractors when they register a patient, as a child (capitation arrangement) or adult (continuing care arrangement).

203. As NHS boards make arrangements with independent contractors, assurance around clinical governance fell to the relevant geographic health board.

204. The majority of 1,050 practices in Scotland are independent, providing a mix of NHS and private dental care. Around 10% of practices are Public Dental Service, providing NHS services where staff, including the dentists, are employed by the respective NHS board.

205. NSS Practitioner Services, made and continue to make payments on behalf of NHS boards to independent contractors.

206. Section 26 of the NHS (Scotland) Act 1978 ("1978 Act") places a duty on health boards to enter into arrangements with "contractors" (which can be a body corporate, or optometrist registered with the General Optical Council, or an ophthalmic medical

practitioner (OMP) registered with the General Medical Council (GMC) for the provision of NHS eye examinations. The services provided under these arrangements are known as General Ophthalmic Services (GOS).

207. Despite the "contractor" terminology, there is no "contract" as such in GOS – optometrists, OMPs and bodies corporate can apply to be included on a health board's Ophthalmic List for GOS provision in the health board's area. There are two parts to an Ophthalmic List – Part 1 details the contractors (optometrists, OMPs and bodies corporate) and Part 2 details those optometrists and OMPs who can "assist" a contractor in GOS provision in the health board area.

208. While community pharmacy is classed as a 'primary care' service, policy responsibility does not sit within the Primary Care Directorate, rather it sits with the Pharmacy and Medicines Division within the Directorate for the CMO.

209. The Public Bodies (Joint Working) (Scotland) Act 2014 at Section 1(8) states that health boards must delegate prescribed functions. General dental, ophthalmic and pharmaceutical services are included in schedule 3 of the Public Bodies (Joint Working) (Prescribed Health board Functions) (Scotland) Regulations 2014. This means that since 2014, HSCPs have had a commissioning role but not a contractual or delivery role in these services.

Health Finance, Governance and Value Directorate

210. Richard McCallum has been the Director of Health Finance and Governance since March 2021, having been the Interim Director between December 2019 and March 2021.

211. During the pandemic, Alasdair Black was Interim Deputy Director for Health Finance and Alan Morrison was Interim Deputy Director for Health Infrastructure and Investment. When the Directorate for PPE became a Division of Health Finance, Governance and Value Directorate in July 2020, Caroline Jack was Interim Deputy Director until December 2020, with Alan Morrison assuming responsibility when PPE became a Unit in Health Infrastructure, Investment and PPE Division in January 2021.

212. The Directorate for Health Finance, Governance and Value was an established Directorate prior to the pandemic, operating as a dedicated financial management

service for the HSCD. The Directorate works with internal stakeholders and external stakeholders (NHS boards and HSCPs) to:

- devise and implement financial strategy for the health and social care portfolio
- financially manage NHS boards, delegated health functions within the HSCPs and internal health directorates
- devise and implement policy and structured investment in NHS infrastructure
- provide advice, insight and intelligence to Ministers and policy colleagues on inter- and cross-portfolio matters.

Impact to Scottish Government policy of UK Government funding decisions

213. UK Government funding did impact on Scottish Government's ability to implement different measures during the pandemic as affordability is one of the factors that Scottish Ministers consider before implementation. Further explanation on the Barnett consequentials can be found within the Module 1 Director General Scottish Exchequer corporate statement, provided to the Inquiry on 19 April 2023. Affordability is one of the factors that Scottish Ministers would consider before implementing measures. The Scottish Government was reliant on UK Government funding for measures that would likely involve significant costs, for example, high volumes of PPE, a testing infrastructure being in place, and later, vaccines supply and roll out. For measures such as the use of face coverings, hand hygiene and ventilation, it was less dependent on UK Government funding as they could be achieved through guidance, messaging, and legislation without prohibitive financial outlay.

214. Participation in the UK-wide funded four nations elements of the Covid-19 response enabled a range of measures, including population wide testing, and supported the implementation of isolation as a non-pharmaceutical intervention to reduce transmission. For most of the period of the main phases of the pandemic, UK Government funding decisions had no impact on specific decisions on the implementation or modification of self-isolation guidance in Scotland. There were no direct cost consequences, other than the negligible costs of system and guidance changes in respect of implementation or alteration of isolation guidance in Scotland. Chronologies of Four Nations Health Ministers meetings and, separately, Four Nations Chief Medical Officers meetings have been provided to the Inquiry.

215. At latter phases of the pandemic, post vaccination – when the public health rationale for population wide testing, tracing and isolation had reduced – decisions in Scotland around the pace of transition to a steady state with specific isolation guidance replaced by general Stay at Home guidance were affected by UK Government decisions including on funding.

216. The governance which existed within UK Government departments was not designed to facilitate decision making on an equal basis for the four nations, particularly in areas such as health, where decision making is devolved. Particularly in the early set up of services, but also through the peak of the pandemic response, decisions were routinely made within UK Government governance structures, with Scotland being informed of the decisions taken and were largely therefore recipients of the decisions made by UK Government. This way of operating was of lower impact in areas where policy in each nation was fully aligned but became problematic where policies differed or where timescales for implementation differed. An example of this would relate to the timing of school terms, which differ particularly in the start of summer holidays and therefore meant a differing timescale for return to school testing. Similarly on decisions on the level of funding available for Covid-19 services such as testing, these have remained decisions taken by the UK Government, rather than being decisions taken on a four nations basis.

217. In early 2022, the UK Government's decision to cease testing in most circumstances in England impacted on available consequential funding for the Scottish Government. The outcome of this limited the Scottish Government's ability to decide on the length and nature of transition of Test and Protect. The transition plan, including the changed strategic intent, was set out online.

218. The then First Minister set this out in a statement to Parliament on 15 March 2022:

"Regrettably, our freedom of manoeuvre here is severely limited by the fact that our funding is determined by UK Government decisions that are taken for England. However, we have sought, as far as we can, to reach the right decisions for Scotland. It is important to note that we are aiming for the same long-term position as England on testing. However, we consider that the transition should be longer. In England, testing for people without symptoms ended in mid-February and will do so at the end of this month for those with symptoms."

<u>Covid-19 financial controls and governance</u>

219. Within the HSCD, the Directorate ensured appropriate financial governance principles were implemented with effect from 13 March 2020 to support necessary decision making, often at short notice, while ensuring that pandemic response activity complied with revised Scottish Government financial policy. These principles were in place throughout the entire period of pandemic response, and included:

- revision of delegated authority to allow Directors and Deputy Directors within the DG to approve spend up to £1 million
- agreement of all spending decisions in excess of £1 million by the Planning and Assurance Group (while in existence) or Health and Social Care Management Board prior to formal approval by Ministers.

220. All spending requests were accompanied by an Accountable Officer template ("AO template") aligning to the wider corporate approach taken across DG Corporate and DG Scottish Exchequer for Covid-19 accountability across the whole of Scottish Government. The AO template required that the following were taken into consideration prior to allocation of funding:

- whether proposed spend was novel or contentious
- under what statutory or budgetary powers was the spend to be directed
- cash availability, ensuring that the Scottish Government's Treasury and Banking team were cited on significant outlays
- whether spend would have implications for procurement on either existing or pending contracts.

221. Similar arrangements were agreed for use across NHS Boards, with:
- initially, delegated authority of up to £1 million for Covid-19 spend, with requests over this level subject to scrutiny by Scottish Government officials
- latterly, authority to spend against signed-off local mobilisation plans, with spend in excess of this still requiring further approval from Scottish Government.

222. Mobilisation plans were continually updated by NHS Boards over the period of response and included details of planned and actual Covid-19 response activity. During initial response, a specific delegation was provided for NSS National Procurement of up to £2 million to support increasing stocks of consumables.

223. The guidance was designed to ensure that financial and related activities were performed in accordance with Scottish Government policy at all times. This ensured the following key principles of managing public money: probity, accuracy, economy, efficiency and effectiveness. Documentation relating to decision-making (both within DG HSC and NHS boards/Integration Authorities) during the period of the Covid-19 response has been retained by the Health Finance, Corporate Governance and Value Directorate, including those decisions which were not taken forward or approved by the HSCMB and/or Scottish Ministers.

Additional funding received during pandemic response

224. An overview of the budgetary process – including funding provided to DG HSC and how this flows to the relevant health bodies has been provided in the Module 1 DG Health and Social Care statement provided to the Inquiry on 09 May 2023. An overview of the financial structure of the Scottish Government and how funding decisions relating to the Covid-19 response were taken is set out in the Module 2A Financial Management Directorate statement, provided to the Inquiry on 23 June 2023.

225. As noted in Module 1, where additional funding is provided for devolved matters in England (e.g., in health, education etc), this gives rise to Barnett consequentials which then flow to Scottish Government. Since 2010-11, consequentials associated with health funding have been protected for direct pass-through to the Health Portfolio and this continued to be the case for additional funding pertaining to the Covid-19 response.

226. Budget documents relating to the specified period, and showing total funding allocated to DG HSC Directorates, and are produced:

- Scottish Budget 2019-20, (CL3/0062 - INQ000147381)
- Scottish Budget 2020-21, (CL3/0063 - INQ000147382)
- Scottish Budget 2021-22, (CL3/0064 - INQ000147383)
- Scottish Budget 2022-23, (CL3/0065 - INQ000147384)

227. Additional consequentials were received during the pandemic and passed to DG HSC at the extraordinary Summer Budget Revision (May 2020), (CL3/0066 - INQ000147419), and at the routine Autumn (September 2020), (CL3/0067 -

INQ000147420), and Spring (February 2021) Budget Revisions, (CL3/0068 - INQ000147421).

Digital Health and Care Directorate

228. Caroline Lamb's substantive post was Director for Digital Health through the period, from January 2020 to January 2021. The disruption throughout 2020 and 2021 required staff who were not working at the point of care to work remotely, and service providers needed to adapt as we managed our response to the pandemic. The important role of digital tools, the use of data and digitally enabled services has been highlighted from the beginning of the Scottish Government's response to Covid-19.

229. Specifically, the Digital Health and Care Directorate team have worked in partnership with organisations including NHS24, NHS National Services Scotland, the Digital Health and Care Innovation Centre, NHS Education for Scotland, National Digital Service and Public Health Scotland to oversee the delivery of the core Covid-19 response elements around shielding, Test and Protect, the Proximity App and the vaccination programme.

230. Key areas where digital has supported service continuity and new solutions include primary care; mental health; remote health monitoring; social care; care at home; supporting individuals shielding; and peer support and workforce solutions.

231. Being able to use digitally enabled services requires people to have access to devices, connectivity and the skills to use the device. The importance of digital inclusion has been underscored and, along with the raised awareness across all policy areas, resulted specifically in the Connecting Scotland initiative. The objective of this Scottish Government initiative, managed by the Scottish Council for Voluntary Organisations, was to increase the number of individuals and families who are digitally connected.

232. Full details on the response from the Digital Health and Care Directorate can be seen in a report published in July 2021 (CL3/0069 - INQ000147422). This included details of how all NHS staff were supported to make use of Microsoft Teams to better collaborate and work remotely/reduce unnecessary contact, how patients were enabled to access appointments via video consultations (through NHS Near Me), how technology was rapidly stood up to facilitate **contact** tracing and, ultimately, vaccine scheduling and

recording, and how a range of technologies were accelerated to enable patients and their families to remain connected and supported, whilst minimising contact.

Mental Health Directorate

233. Mental Health Directorate was established as a standalone Directorate in December 2021, having previously been part of the Directorate for Mental Health and Social Care. The Acting Director is Hugh McAloon.

234. The Directorate leads on mental health policy and on the delivery of the mental health aspects of the Programme for Government, the Mental Health Transition and Recovery Plan, the co-operation agreement with the Green Party, and other key Government commitments. The Directorate leads on the engagement with mental health services including NHS Board engagement and operational planning, performance and escalation.

235. The Directorate works on a cross-Government basis to ensure that mental health is embedded in the work of other key Scottish Government portfolios.

236. The Directorate is responsible for development and delivery of policy to improve mental health, including:

- mental health services: quality, improvement, performance & safety
- mental health workforce
- mental health care standards
- forensic mental health services and management of restricted patients
- learning disability, autism and wider neurodiversity
- dementia
- mental health law
- children and young people's mental health
- families and relationships
- wellbeing and prevention, including social determinants of mental health
- suicide prevention
- distress interventions.

237. The Directorate is supported by a Strategy and Co-ordination Unit, and an Investment and Transformation Unit. These Units cover strategic policy oversight, our approach to equalities, budget management, and governance and portfolio oversight.

238. Rather than being split into separate Divisions, the Directorate operates as three "clusters" – Improving Mental Health Services, Improving Mental Health and Wellbeing, and Improving Complex Care. This maximises our ability to work collectively and collaboratively to deliver our overall policy ambitions.

239. Mental Health was prioritised in NHS operations and mobilisation planning during the Covid-19 Pandemic. Ministers set out clear direction through a set of Directives and Principles and created a network of mental health leads in NHS boards to support the response. The network now supports policy development and delivery and is an important legacy of the pandemic period.

240. Recognising the impact that the pandemic would have on wellbeing and levels of emotional distress, the Directorate took a series of actions to promote population mental health. These included launching the “Clear Your Head” marketing campaign and website; expanding the NHS24 Mental Health Hub to a 24/7 service; and making the Distress Brief Intervention programme accessible nationwide through NHS24.

241. The Covid-19 Pandemic drew a renewed and sustained focus on mental health and wellbeing. In October 2020, we published our Mental Health Transition and Recovery Plan, which laid out a series of actions based around inequalities that were exacerbated during the pandemic.

242. We continue to evolve our policy response to changing mental health need following the pandemic and will publish a new Mental Health and Wellbeing Strategy in 2023 to lay out our updated policy direction.

Data Analysis

243. The decision making by DG HSC was underpinned by a data, evidence and analysis infrastructure. There were related functions for collating and presenting scientific evidence including the Covid-19 Advisory Group. A Covid-19 Health and Social Care Analysis Hub was established in the HSCA Division to develop initial work to manage the collection, analysis, and publication of Covid-19 data. The HSCA Hub worked in

close collaboration with a newly formed Scottish Government Covid-19 Modelling and Analysis Hub (latterly part of DG Strategy and External Affairs). The Covid-19 Modelling and Analysis Hub was established in March 2020 and in January 2021 the Hub evolved to become the Covid-19 Analysis Division. The Covid-19 Hub and subsequent Division was established as a corporate function. This was by deliberate design to enable the division to respond to the convergence of the pandemic with a range of public health, social policy and economic risks. By sitting outwith the main public health response, the division was able to provide a cross office four harms perspective, to triangulate a wide range of data and evidence, to provide briefing, analysis, challenge and advice. Further information on the work of the Covid-19 Analysis Division is provided within the Module 2 DG Strategy and External Affairs corporate statement, provided to the Inquiry on 23 June 2023.

244. HSCA drew on data from several sources to provide briefing to Scottish Ministers and officials on the latest Covid-19 daily data. This included data from PHS on Covid-19 cases, tests, deaths and vaccinations; data from National Records of Scotland on deaths where Covid-19 was mentioned on the death certificate; data from NHS Boards on patients in hospital and ICU with Covid-19; data from care homes on confirmed cases of Covid-19 amongst care home residents and staff, and the visiting status of care homes; data from schools on attendance and absence for Covid-19 related reasons; data from NHS Education for Scotland (NES) on NHS staff reporting absent due to Covid-19; the Office for National Statistics provided data on infection rates from the Covid-19 Infection Survey; Local authorities provided weekly management information on the support offered to those in need during the pandemic and for those who needed to self-isolate.

245. HSCA worked closely with PHS to rapidly develop new data collections and reporting over the course of the pandemic. This included work to develop new reporting for the Covid-19 vaccination programme, interactive reporting on the PHS Daily Dashboard, and continual review and update to content in the PHS weekly Covid-19 statistical report.

246. Early in the pandemic, the HSCA Division established a team to understand the data originating from the nascent testing system. This team evolved to provide regular test capacity modelling that mapped the eligible groups for Polymerase Chain Reaction (PCR) testing to support key operational decisions around system capacity. Data and modelling developed in concert.

247. This work drew on several data sources – both epidemic modelling from Central Analysis Division in Scottish Government and testing management information provided by NHS Scotland and the UK Government – to understand how test demand would change at a Scotland wide level. It also drew on data from regularly published NRS population statistics and PHS secondary care data. The modelling team expanded its scope as LFD testing became widely available and this began to drive PCR test demand. The team also used behavioural data collected as part of regular Scottish Government surveys to better understand testing behaviour in the run up to Christmas 2020 and 2021.

248. HSCA delivered a regular cross-Scottish Government presentation to testing oversight groups called the Test and Protect Data Analysis slides. This product drew together data from across the Scottish Government response [PHS, ONS, NHS data; HSCA and Central Analysis modelling, YouGov surveys] and sought to make this accessible to senior decision makers by evolving a set of key messages relevant to testing decision makers with each iteration. This helped to turn data into insights, drawing out an analytical interpretation to assist decision-making.

249. This presentation was often delivered as a 10-minute presentation at the start of regular test and protect meetings e.g., Testing Operational Delivery Group and Test and Protect Steering group. These meetings had representatives from Scottish Government and NHS (territorial boards and PHS). As part of ongoing analytical engagement with the JBC, the methods behind the presentation were presented at a stand-up call on 31 August 2021 to disseminate the analysis more widely. The JBC stand-up call was a regular show-and-tell session, and HSCA were only invited once to give this presentation.

250. HSCA also provided Covid-19 daily data to the Cabinet Office to feed into their internal dashboard. The Cabinet Office provided a template (excel spreadsheet) and requested data for selected indicators.

HSCA Modelling

251. The testing model output and scenario modelling were regularly part of the advice given to Ministers. This data was presented and discussed both via email, in calls and widely disseminated and debated as part of the Test and Protect oversight structures.

These included the Test and Protect Steering Group, Testing Operational Delivery Group and Test and Protect meetings. These groups included both internal (to SG) and external members working in NHS Scotland. For example, the Test and Protect Steering group regularly had attendees from the public health teams of NHS Scotland, who often asked questions about the national level data and how it related to their local area. These fora allowed for open discussion of data interpretation and bringing together diverse model outputs.

252. Modelling on vaccine delivery was undertaken in the HSCA Covid-19 Testing and Vaccination Modelling team. This team's modelling focused on operational support and programme delivery modelling, rather than epidemiological or clinical modelling of vaccinations.

253. The vaccines models had close engagement from policy, workforce, health boards, and operational colleagues from the beginning. This was especially focused on developing a core set of modelling assumptions that would broadly reflect the expected reality and crucially be of informational value to colleagues. Findings were typically presented at operational stand-up meetings with policy and operational colleagues, with more final outputs subsequently presented and discussed at FVCV Programme Boards and Delivery Groups. Where appropriate modelling outputs were also taken and presented to the Cabinet Secretary for Health and Social Care.

254. A lot of the modelling was an iterative process with operational assumptions and policies being fine-tuned, re-modelled, and then presented again. This was possible due to the open discussions available through the various fora that we worked with. During the initial first and second dose phase between December 2020 and August 2021, a Multi-Disciplinary Team (MDT) was also in operation for much of this period with members from PHS on data, Scottish Government on operations, policy, and modelling, NSS on supply, and Health board representatives. This was the main forum that the team's modelling outputs was presented from a supply perspective, to help manage adequate stock levels for second doses

255. Self-isolation support grant modelling was discussed within analytical and policy teams to inform spending analysis.

<u>Covid-19 daily data published by the Scottish Government</u>

256. Covid-19 daily data was published by HSCA on the Scottish Government website at 2pm each day. PHS are now responsible for publishing headline Covid-19 data (from April 2022). This was presented clearly with short commentary to describe the latest figures, alongside spreadsheets to provide a record of past data and allow users to see the trends. Information on the sources and definitions for Covid-19 daily data were also published on the Scottish Government website on the "Coronavirus (Covid-19) data definitions and sources" webpage.

257. In April 2022, the Scottish Government completed a review of the content and frequency of Covid-19 public reporting working in partnership with PHS and other analytical partners. Given the changes to testing policy and consequent reduction in the quantity of available data, the approach to reporting was reviewed and various changes implemented. Various communications were published to update users on the changes to public reporting during the phased transition to the new approach for testing and are provided to the Inquiry:

- Scottish Government blog on 'Future of COVID-19 Data Reporting' – published 5 April 2022, provided, (CL3/0070 - INQ000147385)
- PHS news article 'Future of COVID-19 reporting' - published 11 April 2022, (CL3/0071 - INQ000147386)
- PHS news article 'Update to reporting of COVID-19 statistics' - published 3 May 2022, (CL3/0072 - INQ000147387)
- PHS news article 'Update on changes to reporting of COVID-19 statistics' outlining the move to weekly reporting – published 1 June 2022, (CL3/0073 - INQ000147388).

The Covid-19 Data and Intelligence Forum

258. The Covid-19 Data and Intelligence Forum was set up in June 2020 to ensure effective coordination and coherence across the various Covid-19 data and intelligence streams that flow within the Scottish Government and between Scottish Government, PHS and NSS as the main providers of Covid-19 data and analytical products and infrastructure solutions. It was co-chaired by Anita Morrison, Head of HSCA and Scott Heald, Director of Data and Digital Innovation, PHS.

259. Regular meetings took place between HSCA and ONS to secure Scotland's participation in the ONS Covid-19 Infection Survey and to share advice and manage

the data flows and publication of data from the survey. However, this group was not involved in 'medical and scientific advice'.

Structures and process for considering data

260. The Covid-19 Advisory Group (C19AG) 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 C19AG were part of a large pool of expert and clinical advisors. Scottish Government teams received advice from a range of sources such as PHS, CMO and colleagues, policy officials, and others on the Covid-19 situation and potential impacts in Scotland.

261. C19AG applied the advice coming to the four nations from the SAGE and other appropriate sources of evidence and information and used it to inform local decisions in Scotland during the pandemic. 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.

262. Scottish Government teams received advice from a range of sources such as PHS, CMO and colleagues, policy officials, and others. From May 2020, the Covid Co-ordination Directorate was established, and a process was put in place for decision making, including the Strategic Framework. The Four Harms Group led by CMO's office together with input from different policy areas.

263. The Shielding/Covid Highest Risk division regularly relied on information and expertise from the Clinical Leads Advisory Group (CLAGS) and from the Deputy NCD (DNCD) and Clinical Advisory Lead John Harden. The team also had access to data from PHS, worked closely with HSCA to receive regular updates on data specific to the people on the Shielding List and received modelling data (e.g., the four 'worlds') from the Central Analysis Division within Scottish Government. All of this was used heavily for scenario planning in relation to what the potential futures might mean for people on the Shielding/Highest Risk list.

264. The Shielding/Covid Highest Risk Division, on behalf of the DG HSC, did not generate or commission its own expert, medical and scientific advice. To assist us in providing advice to the Scottish Government, we received expert, medical and scientific advice from the four CMOs across the UK. At the beginning of the pandemic, and

continuously throughout, the four nations CMOs made decisions on who may be at highest risk from Covid-19.

265. Within the Shielding/Covid Highest Risk division, the Clinical Policy Unit was developed which considered and discussed expert, medical and scientific advice with reference to those at Highest Risk of Covid. The advice was coordinated by DNCD John Harden via CLAGS.

266. Throughout the period 14 May 2020 (the date of the group's first meeting) – 30 April 2022, the Shielding/Covid Highest Risk division drew advice/recommendations for the Scottish Government from the Clinical Advisory Leads Group for Scotland (CLAGS), an expert group led by DNCD John Harden.

267. Data scientists at the University of Oxford provided the Covid Highest Risk Division with advice and information on the QCovid risk stratification model, and their input, discussed and considered via the QCovid Delivery Group, helped Shielding/Covid Highest Risk division provide advice to the Scottish Government on the deployment of this model in Scotland. The intention of this work was to explore how the model could be used as part of Scottish Government's Covid-19 response by stratifying Scotland's population based on their risk of negative outcomes if they were to catch Covid-19. The Usher Institute at the University of Edinburgh were also integral in providing us with expert advice around the EAVE 2 data set and how it could work with the risk stratification tool, again informing our advice to Scottish Government on this work. This work began in May 2020 and ended on 20 April 2022.

268. On 10 June 2020, the Royal College of Paediatricians and Child Health (RCPCH) released updated guidance to clinicians stating that not all children and young people currently advised to shield need to continue to do so: RCPCH releases guidance for clinicians on shielding children and young people (CL3/0074 - INQ000147389). This guidance was used by the Shielding/Covid Highest Risk Division to advise Ministers in a submission (with endorsement from CLAGS) that not all children and young people were required to continue shielding (CL3/0075 - INQ000147390).

269. The Shielding/Covid Highest Risk division also worked with the BMA, RCGP, medical charity stakeholders and CLAGS to obtain their data and advice to help shape policy and communications responses to those on the Highest Risk List. For example, they inputted into the 'Everyday Activities' booklet which was created in November 2020 to

help those most at risk by providing practical advice on risk assessing day-to-day activities, to ensure that they felt safe and protected, produced (CL3/0076 - INQ000147391).

Healthcare Associated Infections Policy Unit

270. All relevant healthcare associated infection expert, statistical, medical and scientific evidence/advice was provided to the Healthcare Associated Infections Policy Unit, by the Covid-19 Nosocomial Review Group (CNRG) and/or Antimicrobial Resistance and Healthcare Associated Infection Scotland (ARHAI) Scotland. Advice and evidence included infection prevention and control measures such as, respiratory protective equipment, physical distancing, healthcare worker testing and face masks and face coverings guidance.

271. Scottish Government Professional Clinical Advisors reviewed information received and requested additional advice if the evidence was unclear. Officials prepared and presented the evidence or advice received from expert groups and bodies into a standard ministerial template which aimed to support Ministerial decision making. All briefings were reviewed and cleared by Professional Clinical Advisors and Senior management prior to issuing to Ministers. Relevant officials across Scottish Government were copied into the briefings sent to Ministers via email, in order to ensure officials across the Scottish Government were aware of progress.

272. On the occasions that Ministers required further clarity or discussion, officials would source the necessary information (perhaps returning to CNRG, ARHAI or engaging with the Professional Clinical Advisor) and would either respond to their queries directly, provide an updated briefing or arrange a meeting. Any meetings with a Minister would include the relevant officials and the unit Professional Clinical Advisor.

273. The Healthcare Associated Infections Policy Unit provided Ministers and relevant officials with a summary of the Covid-19 clusters in NHS Scotland over the course of the pandemic. This information was initially provided daily however is now provided weekly. The Covid-19 cluster summary gives details of the number of amber or red assessed clusters across the Boards with some key information around if there have been patient deaths associated with the cluster or any lessons learned in relation to transmission risks or control measures that week. This information helped Ministers to understand the spread and severity of infection incidents in hospital settings. This

information in the Covid-19 cluster summary is reported by NHS Boards to ARHAI Scotland who collate this information (ward level data, numbers of patient/ staff affected/ number of deaths and assessment of cluster rating (red/ amber/ green) and send to the policy team. The information in the cluster summary is reviewed by Scottish Government Professional Clinical Advisors who requested additional information from ARHAI if needed.

Sharing data and statistical modelling with key stakeholder groups

274. The Health Workforce Directorate disseminated selected data and statistical modelling in confidence to key stakeholder groups within Health and Social Care both by email and verbally within forum meetings. Data shared included but was not limited to: "Covid-19 Daily dashboard" – Public Health Scotland; "PPE Supply update" – NSS; "State of the pandemic presentation slides" – National Clinical Director.

275. Stakeholder groups included:

- Workforce Senior Leadership Group (WSLG)
- NHS Board Chief Executives
- NHS Board Chairs
- NHS Human Resources Directors (HRDs)
- NHS Employee Directors (EDs)
- Scottish Partnership Forum (SPF)
- Scottish Workforce and Staff Governance committee (SWAG)
- STAC.

Workforce planning

276. From a Health Workforce perspective, the availability and sophistication of any modelling data evolved over the course of the pandemic. In the early part of the pandemic, the team were not making use of forecasting data as such (and did not have a reliable forecast model for a coronavirus type pandemic). Arrangements were quickly put in place to extract weekly data from SWISS (the workforce information system) in order to apprise Ministers of actual absence levels across the service and also began recording coronavirus related absence (against a number of different categories, including caring responsibilities, self-isolation etc).

277. In the very early part of the pandemic, health workforce relied on the UK Government Pandemic Influenza Planning Guidance (CL3/0077 - INQ000147423).

278. Planning assumptions for an influenza related pandemic posited peak absence of c. 15-20% within a 26-week pandemic-curve time-series, with a very high incidence of overall infection. This information was then used to inform staffing policy decisions, including the introduction of measures to support the rapid recruitment and deployment of additional staff, with measures to support the rapid recruitment of retirees and returners (which included those admitted to the GMC, Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) emergency registers). Planning assumptions on potential staff absence were disseminated within the DG, including to the PAG and CNO. This data informed decision making in connection with the deployment of nursing and allied health professional students on paid placement from April/May 2020.

279. Over time, actual data to model peaks and troughs in absence was used to model new waves against previous waves (particularly from 2021 onwards) – this allowed a fairly reliably pointing to the emergence of peaks of rapid rise, peak absence, plateau and rapid descent. Through winter 2020 and winter 2021, HSCA modelled 6 week 'forward look' workforce absences for key job families (nursing and medicine, and other staff) predicated on other epidemiological data and projected hospital occupancy (as a proxy for the incidence of infection amongst health service staff). This data helped us to inform the suite of winter pressures workforce interventions over the course of those two years but highlighted also the limited capacity to very quickly generate adaptive workforce responses given the long lead-in times for new workforce. By the time data emerged confirming the existence of a new variant and or the emergence of a new Covid-19 wave of infection, the available response time invariably led to repeated efforts to maximise supplementary staffing routes and flexible deployment.

280. Following the ending of routine testing and self-isolation requirements, staff absence recorded as related to Covid-19 has dropped precipitously. There is however also a relationship between wider sickness absence rates and the pandemic effects on population health that is yet to be fully explored. In a future pandemic, absence would be modelled differently - including the rapidity of peaks and troughs of absence for a disease that can present multiple contemporaneous and/or sequential waves of infection and which doesn't have a settled seasonal pattern.

281. It is also clear that there is a much more complicated relationship between workforce absence and system capacity that was not fully appreciated at the onset of the pandemic. Absence is an indicator of system capacity, but overall workforce capacity is more directly and immediately affected by decisions to suspend and or amend aspects of service delivery to redirect staffing to pandemic response. Workforce capacity challenges were a more significant issue in 2021 and 2022, as compared with 2020 and this was not readily identifiable in available workforce data sets. It is also clear that the nature of the modelling data and forecasting data that would be available in the event of the emergence of another pandemic, would require insurance-based workforce models to be pursued, given the issues with reliable forecast periods and lead-in response times set out above.

282. Information and expertise used to inform Health Workforce decisions and policy provisions that were put in place to protect staff included:

- the definition of high-risk clinical groups which were determined by CMO Clinical Cell (a clinical group of specialists providing advice) with input from the CNRG
- the development of individual risk assessment tool for Health and Social Care workers, was informed by the independent Association of Local Authority Medical Advisors (ALAMA) tool (Covid-19 Medical Risk Assessment – Alama) (CL3/0078 - INQ000147392). Regular discussions were held with the creators of the ALAMA tool (the Join Occupational Health Covid-19 group), and three Occupational Health Consultants. Prior to implementation it was agreed by the Clinical Cell, WSLG, CNO, CMO and NCD
- PPE Guidance (CNOD-led) was issued via updates to the National Infection Prevention and Control manual website, CMO Letterhead.dot (scot.nhs.uk) (CL3/0079 - INQ000147393) and CNO(2012)1 - National Infection Prevention and Control Manual for NHSScotland: chapter 1: Standard Infection Control Precautions (SICPs) policy (CL3/0080 - INQ000147394) and which was approved by Antimicrobial Resistance and Healthcare Associated Infection Scotland (ARHAI)(currently a part of NHS NSS) and regularly discussed with CNRG. The use of FFP3 masks, and introduction of policy around a discretionary approach to FFP3 use, was not introduced due to any changes in the clinical evidence but was agreed by CNO, CMO, ARHAI and national health and safety committee.

283. Data on the death of any NHS Scotland staff member from Covid-19 was provided to the Scottish Government by NHS Boards following the issue of Directors Letter (DL) (2020) 12 on 24 April 2020. (CL3/0081 - INQ000147395)

284. Health boards were also advised to provide confirmation that these incidents, where appropriate, have been reported to the Health and Safety Executive ("HSE)" as advised in HSE Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting guidance.

Advisory Structures

Internal Scottish Government Advisory Groups

Chief Medical Officer, Chief Scientific Adviser and Chief Scientist

285. A detailed overview of the role of the Chief Medical Officer, Chief Scientific Adviser and Chief Scientist is set out in the Module 2A Expert Health Entities corporate statement provided 23 June 2023.

Medical Advisory Group/ The Scottish Covid-19 Advisory Group (C19AG)

286. HPS (part of Public Health Scotland from 1 April 2020) played an important role in providing advice to Ministers and NHS Boards throughout the pandemic. A Medical Advisory Group was established in February 2020 by the DCMO and included officials from strategy, health protection, general practice, excess deaths, public health, emergency departments, critical care, obstetrics, paediatrics, acute medicine, older people, infection control and infectious diseases.

287. This group was a precursor to, and subsequently succeeded by, the C19AG which was established to consider the wide-ranging medical information that was crucial to understanding the evolving Covid-19 situation and potential impact in Scotland.

288. A detailed overview of the role of the C19AG is set out in the Module 2/2A Scottish Covid-19 Advisory Group statement, provided to the Inquiry on 23 June 2023.

289. The C19AG first met on 26 March 2020 and 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 C19AG 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 but had no involvement in advice on the political or economic aspects or on the social consequences. It also had no involvement in direct cooperation with certain international organisations with respect to emergency planning for global epidemics/pandemics, including the Covid-19 pandemic.

290. Meetings of the C19AG were usually arranged by the secretariat. However, on occasion, some meetings were arranged through SGoRR. Officials from DG HSC and other parts of the Scottish Government were often invited to observe regular meetings of the C19AG where planned discussion related to ongoing policy developments in that area.

291. In addition to the regular meetings of the C19AG, a number of briefing meetings with Ministers were arranged, referred to as 'Deep Dives.' These meetings provided the opportunity for the independent members of the C19AG to speak directly to Ministers and for Ministers to question experts about the science. Any decisions made in relation to the issues discussed at these briefings were made by the Scottish Government. The C19AG's role, as with its written advice, was only to advise, not decide.

292. Meeting papers, including: an agenda; papers; and presentation; where applicable, were circulated to attendees. If there was not a consensus on the issue or on aspects of an issue, then the minutes or advice made clear where that was the case. Agendas for meetings were agreed in discussion between the Chair and the secretariat, driven by the priority issues at the time – especially where the group had been asked for specific advice – and the need to stay informed of the latest developments in the science, data and modelling.

293. Agendas, papers, and minutes for C19AG meetings are provided to the Inquiry as part of the general disclosure on 28 February. Other than the Deep Dives, and the advice produced by the C19AG, there was no formal or informal contact with Scottish Ministers for the purpose of providing advice.

294. The C19AG provided advice in writing to the Scottish Government in the form of papers setting out the consensus view of the C19AG. Some of this advice was in

response to requests for advice, communicated to the Group via the secretariat. Other advice was provided on the C19AG's own initiative.

295. As members of the Group, the CMO, DCMO, the Chief Scientist (Health), the Chief Scientific Adviser and the senior officials from PHS would normally have been involved in discussing and agreeing advice and they and/or their offices would receive copies of the advice once it issued.

296. The C19AG advice was routinely issued to the:

- First Minister
- Deputy First Minister
- Cabinet Secretary for Health and Sport (subsequently Cabinet Secretary for Health and Social Care)
- DGHSC and Chief Executive of the NHS
- NCD
- Covid Public Health Director
- other senior officials involved in the response to Covid-19.

297. Ministers and senior officials would also routinely receive a brief informal report following meetings of the C19AG, noting the issues discussed, in advance of the formal minutes of the meeting.

298. The C19AG secretariat has collated all key materials from the group, including, copies of advice issued by the Group, and update emails and these have been provided to the inquiry. The Group last met on 03 February 2022. While the Group is dormant, it can be reconvened if necessary.

299. The Group's full Terms of Reference and membership are published on the Scottish Government website. All papers considered by the C19AG at their meetings are also published and have been previously made available to the Inquiry. A chronology of the meetings of Covid-19 Advisory Group is provided (CL3/0082 - INQ000147396).

300. It is important to note that the C19AG were part of a large pool of expert and clinical advisors. Scottish Government teams received advice from a range of sources such as PHS, CMO and colleagues, policy officials, and others. Advice was not restricted to a

single source and reference is made to the exhibit produced in paragraph 306 in relation to advisory groups and sources of evidence.

301. The C19AG had a number of subgroups: the Covid-19 Nosocomial Review Group, the Advisory Sub-Group on Education and Children's Issues, the Advisory Sub-Group on Public Health Threat Assessment and the Advisory Sub-Group on Universities and Colleges. The Inquiry has been provided with the minutes and papers of these groups as part of the general disclosure to the Inquiry as part of the general disclosure on 28 February.

302. The C19AG identified Covid-19 testing as a priority area on which it gave advice to the Scottish Government and CMO. The Scottish Government and the Advisory Group agreed to establish a dedicated sub-group to provide additional scientific advice in relation to Covid-19 testing.

The Scottish Government Scientific Strategic Advisory Board on Covid-19 Testing

303. The Scottish Government Scientific Strategic Advisory Board on Covid-19 Testing (SABoT) was operational from April 2020 to March 2022 and was chaired by Professor David Crossman, Dean of Medicine at the University of St Andrews, and Chief Scientist (Health) at the Scottish Government.

304. This Board considered the scientific and technical concepts and processes key to supporting the delivery of Covid-19 testing; and informed the Scottish Government's strategic use of testing to manage the pandemic. The advisory group considered emerging scientific evidence and other appropriate sources of information to inform local decisions in Scotland during the pandemic. The advisory board provided expertise and advice to inform Scottish Ministers but did not take a role in policy decision making.

305. The SABoT's remit was to:

- provide an ongoing review of testing strategy within Scotland in light of emerging scientific evidence and changing prevalence of the disease
- recommend strategies for the delivery of testing, including the evaluation of different testing types, considering new methods of testing, and the need to have sufficient testing capacity to meet demand
- consider emerging evidence to inform current testing priorities and recommend which groups within the Scottish populace should be prioritised for testing

- provide an expert point of contact with, and strategic input to, the Scottish Government Covid-19 Advisory Group
- evaluate the efficacy of Covid-19 testing strategy and practice across the UK and thereby provide advice to inform Scottish provision.

306. The minutes, agendas and papers from the (SABoT) were provided to the UK Covid-19 Inquiry as part of general disclosure on 28 February 2023.

Tripartite partnership working groups

307. The Scottish Government's Health Workforce Directorate also oversees long-standing tripartite partnership working groups, including the Scottish Partnership Forum, the Scottish Workforce and Staff Governance Group, and the Scottish Terms and Conditions Committee, which include representation from the Scottish Government, NHS Employers and Trade Union representatives. These forums provide policy recommendations on matters of staff governance within NHS Scotland. In early 2020, these established forums were used to seek advice and guidance on matters arising affecting staffing, in connection with the pandemic.

308. It was recognised in March 2020 that a supplementary forum with members from both Health and Social Care would be beneficial. This led to the creation of the Coronavirus (Covid-19) Workforce Senior Leadership Group (WSLG).

The Coronavirus (Covid-19) Workforce Senior Leadership Group (WSLG)

309. The WSLG was established on 23 March 2020 and chaired by Gillian Russell, Director of Health Workforce. Made up of members from both Health and Social Care, its purpose was to:
- inform, engage and take collective action on key issues identified that require national senior strategic leadership in the health and adult social care workforce response to Covid-19
- work in partnership to ensure that the healthcare system was as prepared as it could be to respond to the peak of the virus, during and post response
- ensure timely feedback from NHS Boards and Trade Union/ Professional Organisations for the WSLG to address key issues.

310. Key issues and topics that were raised and discussed included but were not limited to: PPE, vaccinations, self-isolation, staff testing, sickness absence, school closures, and various Health Workforce policies.

The Scottish Terms and Conditions Committee (STAC)

311. In addition to the WSLG, the STAC significantly increased its meeting frequency to enable discussion and rapid decision making on necessary adjustments of existing provision including variation orders from extant Health Workforce. The Terms of Reference and relevant papers will shortly be provided to the UK Covid-19 Inquiry.

Health Workforce Groups

312. Health Workforce Directorate also convened various other groups, at pace, to inform decision making on specific aspects of Health Workforce policy including:

- Health and Social Care Workforce Wellbeing and Mental Health Network oversight group (established 29 September 2020) (CL3/0083 - INQ000147397)
- Health and Social Care Workforce Wellbeing and Mental Health Network Programme Board was established on 19 March 2021. (CL3/0084 - INQ000147399)
- Workforce Specialist Service (established on 7 January 2021) (CL3/0085 - INQ000147462, CL3/0086 - INQ000147464, CL3/0087 - INQ000147465, CL3/088 - INQ000147401)
- Future Vaccination Workforce Advisory Group (established on 16 February 2021) (CL3/0089 - INQ000147402)
- Strategic group on Healthcare Student Placements (established 7 October 2020) (CL3/0090 - INQ000147403)
- Future of Test and Protect Workforce Group (established January 2022) (CL3/0091 - INQ000147404).

Adult Social Care PPE Steering Group

313. This group was established to manage the Social Care PPE Hub Network from a strategic perspective. The minutes from the meetings of the Adult Social Care PPE Steering Group are being processed and will shortly be shared with the UK Inquiry. An Adult Social Care PPE Steering Group was established, which was chaired by Scottish

Government officials and whose membership consisted of the representatives from the organisations that co-signed the Memorandum of Understanding relating to PPE Hubs (see paragraph 137-139 above). The Steering Group monitored the use of the PPE Hubs and levels of supply and demand, in addition to addressing ad hoc issues of concern raised by Steering Group members.

314. The PPE Steering Group was not a decision-making group. Instead, it existed to oversee delivery function and ensure continued support for care providers for as long as was required for the pandemic.

Adult Social Care Testing Board (ASCTB)

315. This was an internal Scottish Government Policy Board with clinicians to provide oversight of the implementation and delivery of the expansion of testing in social care in line with Standard Operating Procedure (SOP) requirements. Ten meetings were held between January 2021 and July 2021.

316. The ASCTB Summary Report October 2021 has been exhibited, (CL3/0092 - INQ000147405). Additional key supporting documents relating to this group have been provided to the UK Inquiry.

COVID Status Certification – Programme Board

317. A Programme Board was established to oversee the development of the domestic Covid Status Certification scheme. A range of key stakeholders were engaged, clear roles and responsibilities established, and an escalation route for key issues put in place. This formal governance mechanism captured progress, key activities and associated risks, and allowed stakeholders from various sectors and operational areas to provide their perspectives on the proposed changes. This, in turn supported Directors and/or Associate Directors with operational decision-making and providing quality advice. The Board was chaired by Richard Foggo, Director of Covid Public Health. The first meeting was held on 2 September 2021. On 10 February 2022, the Board was disbanded with the next phase of programme activities undertaken within the Covid Ready Society and Digital Health divisions, feeding into the wider SG Covid-19 response.

Coronavirus (Covid-19): Ventilation Short-Life Working Group

318. This group was established in August 2021 to provide advice and make recommendations on actions to improve ventilation and support the creation of infection-resilient environments. Membership included local authority environmental health specialists, the building sector, business representative bodies and university academics. The programme of work managed by the group provides advice and support underpinning the delivery of critical policy work to optimise the effectiveness of ventilation in non-healthcare settings. Outputs were considered by Scottish Government officials and ministers and helped to address short-to-medium term priorities, develop long-term ambitions, support private and public sector actions and policy development to improve ventilation. The recommendations and the Scottish Government's response to those recommendations were published (CL3/0093 - INQ000147425) and Parliament kept updated on progress by Ministers.

Coronavirus (Covid-19) Adaptations Expert Advisory Group

319. This Group was established in response to the Covid-19: Ventilation Short-Life Working Group's recommendations. In broad terms, the role of the group was to consider and make recommendations on interventions and innovations that will build resilience to Covid-19 and other infections in the built environment in non-clinical settings. For example, within public sector buildings

Covid-19 Adaptations Steering Group

320. This Group oversees a cross-Government programme of work to deliver the commitments on Covid-19 adaptation outlined in in the Covid-19 Strategic Framework update (an overview of the initial programme is provided at Annex A of the ToR document. The programme will be revised in light of emerging learning. The Group was established to bring together key internal Senior Leaders and Deputy Directors. It is also envisaged that appropriate experts and specialists may be invited to support the steering group and have the opportunity to contribute.Further details of this group, including their objectives and membership can be found in the ToR, (CL3/0094 - INQ000147406).

Scottish Government's Clinical Leads Advisory Group (CLAGS)

321. In May 2020, CLAGS was set up by the Scottish Government. This Group was created on the request of Dr John Harden, DNCD, who took on the role as the Clinical Lead for Shielding in May 2020, in order to support his advice to the CMO and policy officials. This was a group of specialist clinicians with expertise in the conditions covered by the shielding categories. CLAGs provided advice, information, data, proposals and outline approaches to the DNCD for Scotland but was not itself a decision-making body. Dr Harden chaired the Group.

322. The CLAGS Terms of Reference have been provided along with the full list of meeting agendas, minutes and papers.

Identifying Clinically Extremely Vulnerable Group (ID Group)

323. The ID Group was established early in the pandemic to liaise with CMO's office on the definition of groups at highest risk of severe illness or death from Covid-19 on an ongoing basis as new evidence emerged. This included the identification of people to be added to the Shielding List through coding and data searching and liaising with PHS, issuing of letters to people shielding via liaison with NSS, communications with Health boards, GP Practices and secondary care clinicians. The group also created a process for sharing data between public sector partners including PHS, NSS, local authorities and health boards. The group included representatives from Scottish Government areas such as Shielding, Primary Care, Digital Health and Care and partners including PHS, NHS Digitial and NSS.

Regional Resilience Partnerships (RRP group)

324. RRP meetings brought Local Resilience Partnerships (LRPs) and Scottish Government together on a regular basis. These meetings allowed operational issues relating to shielding support programmes (for example, provision of food boxes, access to medicines and priority supermarket delivery slots) to be addressed and to exchange information, and for questions to be raised and resolved. RRP and LRP are multi-agency partnerships made up of representatives from local authorities, NHS, emergency services and voluntary sectors. Guidance for local authorities and Local Resilience Partnerships on support for those who are at the highest risk of severe illness from Covid-19 has been provided, (CL3/0095 - INQ000147407).

Support for People Group

325. The Support for People Group brought together partners such as the Scottish Government Shielding Team, COSLA, SOLACE lead on Shielding, Scottish Government resilience colleagues, Police Scotland, Third Sector, local authority representatives and NES. The group worked on the coordination of shielding work, including shielding assistance programmes, between these partners, and identified and resolved issues that emerged.

QCovid Delivery Group

326. QCovid is a predictive risk model that takes into account a range of factors, (including health conditions, ethnicity, age and BMI) known to increase risk of serious outcomes from Covid-19. The role of the Delivery Group was to have oversight of the work to explore and deploy QCovid in Scotland if appropriate, to better identify those at risk and to prioritise for vaccination, treatments etc. Members of the Delivery Group included senior representation from Scottish Government areas such as shielding, digital health and data, and also from external organisations with a key role in the delivery of QCovid including NES, PHS and University of Edinburgh. The Delivery Group had responsibility for all recommendations to the Cabinet Secretary relating to the programme of work, and for final sign-off of key deliverables. The Delivery Group was chaired by a Director, Michael Kellet.

Health and Wellbeing Reference Group (HWRG)

327. The HWRG consisted of representation from local authorities, Community Health Partnerships, Third Sector, Resilience Partners and the Scottish Government. The group considered, discussed and advised on support needed by the shielding community to maintain their physical and mental health during the pandemic.

328. The Person-Centred policy team established a regular online visiting reactivation forum (VRF) with individuals responsible for hospital visiting in NHS Scotland Health boards. The VRF met regularly throughout the pandemic, initially weekly, then fortnightly and then monthly until April 2022. The main purpose of the group was:

- to communicate Scottish Government policy on hospital visiting
- to receive information from the health boards about how visiting policy was working on the ground

- to use information received from the group to inform policy decisions and highlight issues to senior clinical advisors in the Scottish Government.

Adult Social Care Advisory Groups

329. During the pandemic, Scottish Government officials liaised closely with social care stakeholders through:
- regular attendance at stakeholder network meetings, for example IJB Chief Officer network meetings
- individual meetings with representatives of social care provider organisations such as COSLA (for local government) and Scottish Care (for independent and some third sector providers), Coalition of Care and Support Providers Scotland (CCPS) (for third sector); also, regular meetings with the Care Inspectorate, the regulator, and
- new pandemic groups established to bring stakeholders together to discuss and prioritise actions to support the sector during the pandemic and to advise on the development of guidance.

330. Within the social care division The Pandemic Response for Adult Social Care Responding to the Pandemic Division (now the Adult Social Care Oversight and Assurance Support Division), there were two main stakeholder groups: (I) Clinical and Professional Advisory Group for Adult Social Care (CPAG); and the (ii) Care Home Rapid Action Group, which was (subsequently replaced by the Pandemic Response Adult Social Care Group (PRASCG)).

The Clinical and Professional Advisory Group for Social Care (CPAG)

331. The Clinical and Professional Advisory Group for Social Care (CPAG) was established in April 2020. Its initial remit was to provide clinical and professional advice and guidance for protecting the care home sector during Covid-19 and this was later was expanded to include the wider adult social care sector. The group, which was commissioned by the CMO and CNO, and chaired by a CMO and CNO representative, brought together clinicians and external stakeholders including care home providers, NHS and local authorities to provide professional and clinical advice to Scottish Government. The Group also supported the development and implementation of guidance for the Adult Social Care sector, including clinical and visiting guidance for the

care home sector. Over 80 meetings of CPAG were held during the course of the pandemic, with the last meeting of CPAG held in December 2022.

332. Documents for the the Clinical and Professional Advisory Group for Social Care (CPAG) have been provided to the UK Covid-19 Inquiry.

333. CPAG was an effective forum for collaborative, focussed and appropriate guidance and policy development. When officials were developing a policy, consultation could be conducted efficiently with a wide range of stakeholders and appropriate solutions developed. Members also brought issues to the attention of the Group so that appropriate solutions could be considered. This approach enabled a more significant degree of collaboration than would otherwise have been feasible under the circumstances. The frequency of meetings varied at different phases of the pandemic from twice weekly to monthly.

Care Home Rapid Action Group / Pandemic Response Adult Social Care Group (replaced by PRASCG)

334. A national Care Home Rapid Action Group (CHRAG) was established in April 2020 comprising the key partners with operational oversight and deliver responsibility for care homes. The group received daily updates and was tasked with activating any local action needed to deal with issues as they emerged, as well as informing and coordinating a wider package of support to the sector. The CHRAG initially focused on care homes but in September 2020 was widened to cover adult social care under a new group PRASCG.

335. The Terms of Reference and relevant papers have been provided to the UK Covid-19 Inquiry.

336. PRASCG was set up in September 2020 as a successor to the CHRAG, to provide a multi-stakeholder focal point for the work being undertaken to support the effective delivery of adult social care provision during the continuing coronavirus pandemic.

337. The objectives of the group were to:

- enhance existing collaborative working across adult social care sector leaders
- share intelligence and identify key issues for resolution related to the pandemic (supported by relevant data/metrics/evidence as appropriate)

- share intelligence and identity key issues that continue to hamper recovery from Covid-19
- ensure learning from the pandemic shapes the future as the sector recovers.

338.

Scottish Government Guidance on Adult Social Care

339. The Scottish Government provided advice and guidance to Adult Social Care stakeholders during the pandemic on:

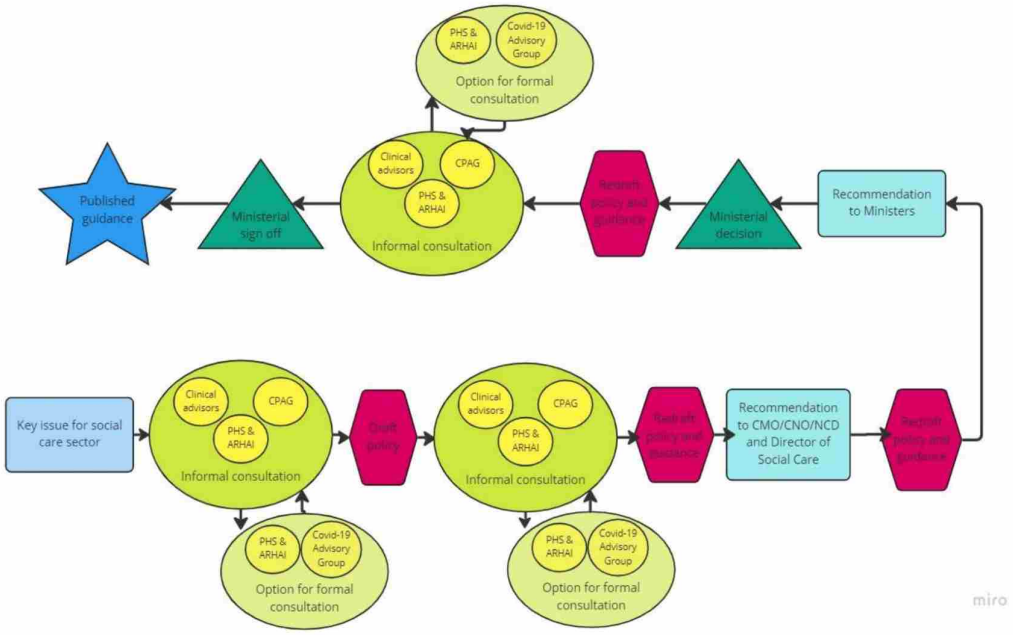
- communications and guidance on pandemic related policy initiatives e.g., the social care staff support fund
- testing arrangements for social care
- funding
- guidance on Covid-19 measures to protect staff and service users (for example, extended use of face mask guidance; visiting guidance and clinical guidance for care homes). Early on in the pandemic there was no specific / standalone guidance for adult care homes, other than a general Covid-19 guidance for social care first published by Health Public Scotland (HPS) on 12 March 2020 titled Social or Community Care and Residential Settings. CMO and CNO issued Scottish Government clinical guidance specifically for adult care homes due to the vulnerability of the care home population.

340. Scottish Government CMO/CNO clinical guidance for care homes drew on the HPS guidance but provided more clinical considerations for the care home population. From 21 April 2020, HPS published specific advice for adult care homes and Scottish Government subsequently withdrew clinical guidance once HPS guidance for adult care homes was well established and contained detailed advice. For the remainder of the pandemic, Covid-19 guidance for social care was published by PHS, with SG publishing standalone detailed guidance for the sector on specific areas - face masks and care home visiting all of which was reflected in PHS Covid-19 guidance for the social care sector.

341. Decision-making typically followed a pattern. When issues came to the attention of officials, there was informal consultation with clinical advisors and stakeholders (public health, care provider representatives, Chief Social Worker Officers, Chief Officers, Nurse Directors, unions, local care home oversight teams) and via CPAG. Policy

advice and guidance was drafted and informally consulted on again before a recommendation was made to the CMO and CNO and Director for sign off. Redrafting could take place again before a recommendation was made to Ministers and, following their decision, guidance was drafted which again would be consulted on before being published. This collaborative process as illustrated below ensured that published guidance was more likely to be appropriate for the sector as it had been developed in conjunction with representatives.

342. Illustrative diagram:



Guidance on adult care home visiting

343. Advice on care home visiting was initially contained in Scottish Government clinical and professional guidance for care homes and in HPS guidance for social care. Early in the pandemic, it was recommended that visiting be restricted to essential visits only for end of life or distress. In June 2020, the Scottish Government published the first standalone visiting guidance outlining a staged approach to allow a return of indoor visiting. Further iterations of guidance, guided by clinical advice, were published to encourage progress through the stages to supporting indoor visiting and visits out of the care homes. In February 2021, Open with Care - supporting Meaningful Contact in Adult Care Homes, (CL3/0102 - INQ000147437), was published to promote a full return to routine indoor visiting. Guidance on visits out and visiting organisations /

professionals was also published. Scottish Government monitored arrangements for care home visiting though the visiting data collection via the TURAS care home Safety Huddle Tool and through the establishment of the Open with Care/ Anne's Law national oversight group.

344. The process for decision and approval of guidance – individual and collective discussions with stakeholders e.g., public health, care provider representatives, clinical advisers and CPAG members; development of guidance signed off by CMO, CNO and NCD and Director of Mental Health and ASC followed by Ministerial sign off.

345. A chronology of key visiting guidance is exhibited.

- Visiting Guidance for Adult Care Homes in Scotland – 25 June 2020, (CL3/0096 - INQ000147431)
- Visiting Guidance for Adult Care Homes in Scotland – updated 8 August 2020 version, (CL3/0097 - INQ000147432)
- Care homes - Covid - Guidance on family and friends visiting - updated 27 August 2020 version, (CL3/0098 - INQ000147433)
- Care homes - Covid - Guidance on family and friends visiting Updated 12th Oct 2020, (CL3/0099 - INQ000147434)
- Care homes - Covid - Visiting - Guidance on family and friends visiting - updated version 1.5 - strategic framework – 16 November 2020, (CL3/0100 - INQ000147435)
- Care homes - Guidance on Family and Friends visiting WEB Vsn – 14 December 2020, (CL3/0101 - **INQ000147436**
- Pandemic Response Adult Social Care -COVID-19 - Open With Care Guidance Document Final-24-02-2021, (CL3/0102 - INQ000147437)
- NES Open with Care Principles Document-01-06-2022, (CL3/0103 - INQ000147438).

Other Healthcare Bodies

346. Healthcare Improvement Scotland (HIS) – HQI worked jointly with HIS to develop a range of resources to support health and social care staff undertake Anticipatory Care Planning (ACP) during Covid-19 including guidance to support GPs, developing an essential ACP tool, guidance on ACP for people with dementia, and links for people on ACP to NHS Inform. HQI also worked with HIS regarding advice to Independent Healthcare Providers and funding for regulation activities during Covid-19.

347. A "Visiting Reactivation Forum" (VRF) was established via MS Teams. It included key individuals in each NHS Scotland Health board responsible for implementing visiting policy locally.

348. Guidance for diabetes services was developed during the pandemic for NHS Inform and Health boards. Patient information guidance for those with specific conditions was also developed, this included respiratory conditions, chronic pain and rare disease. A recovery framework for Pain management services was also developed for Health boards to support essential care.

External Advisory Groups

349. The Scientific Advisory Group for Emergencies (SAGE) first met in response to Covid-19 on 22 January 2020. Its membership includes the Scottish Government's CMO and DCMO. Sub-groups of SAGE include the Scientific Pandemic Insights Group on Behaviours (SPI-B), Scientific Pandemic Influenza Group on Modelling (SPI-M-O), the Serology Working Group, the Covid-19 Clinical Information Network (CO-CIN), the Environmental Modelling Group (EMG), Children's Task and Finish Working Group (TFC), the Ethnicity Subgroup and the Social Care Working Group (SCWG).

350. The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) is an advisory body that advises the United Kingdom CMO for England and from which Scotland's CMO/CNO also received information and advice.

NON-PHARMACEUTICAL INTERVENTIONS (NPIs)

351. From January 2020 to May 2020 consideration of NPIs was at a four-nation level, in line with pre-Covid-19 pandemic preparedness strategies including influenza and subsequently the UK Covid-19 response strategy, with decision making at Cabinet Office Briefing Room (COBR) supported by meetings of SGoRR. Ministers including the First Minister attended these meetings and were supported by officials from various Directorates including the CMO. Decision making on NPIs, ultimately, remained with Scottish Ministers and Cabinet. This is reflected in the different approach taken at different times including differentiation of geographies, and timings of introduction and removal of restrictions. Especially at the outset of the pandemic, this decision making was supported by attendance at COBR and SGoRR. Ministers including the First

Minister attended these meetings and were supported by officials from various Directorates including the CMO.

352. The Scottish Government developed a strategic approach to the use of NPIs to manage the pandemic in Scotland as set out in the Module 2/2A DG Strategy and External Affairs statement, provided to the Inquiry on 23 June 2023.

353. Policy officials within the Directorate for Covid Public Health provided information on various NPIs in non-clinical settings, including face coverings, physical distancing, social mixing, hygiene, ventilation, vaccine certification and working from home to the teams in Constitution and External Affairs that co-ordinated policy, legislation and public guidance on NPIs to be taken into account in advice to Ministers. Advice was also provided in relation to such measures in clinical settings by CNO and CMO office.

354. In relation to the population level measures, the Director of Covid Public Health coordinated advice for the Cabinet Secretary for Health to inform DG HSC and collective Cabinet decision making on NPIs. That advice was always developed in collaboration with senior clinical advisers including CMO, CNO and the NCD as well as advice received from other expert sources including the Covid-19 Advisory group.

NPI Impact Assessments

355. NPI impact assessments are discussed in more detail in the DG Strategy and External Affairs (Ref: M2A-SG-01) statement provided to the Inquiry on 23 June 2023 at paragraph 85.

Sources of Advice

356. Advice was provided from the following sources:

- SAGE advice
- WHO advice
- CMO advice (throughout)
- DCMO and SMO advice (throughout)
- HPS/PHS advice (throughout)
- NCD advice
- CNO advice

- Chief Pharmaceutical Officer
- Chief Dental Officer
- Chief Scientist (Health)
- Chief Scientific Adviser
- Scottish Government Covid-19 Advisory Group.

357. Health and Social Care Analysts provided a suite of statistics on a regular basis. This changed throughout the period and included modelling data, and wastewater data. Information on the state of the pandemic in the UK and beyond was provided by the UKG on a regular basis – initially daily.

358. A timeline of dates of SAGE meetings attended by Scottish Government Officials (and details of the meetings) has been made available to the Inquiry (general document disclosure, (CL3/0104 - INQ000147426

Health Workforce Risk Assessments

359. The Clinical Cell first issued guidance to healthcare workers with underlying health conditions on 30 March 2020. Healthcare workers were then included in the population shielding advice.

360. On 27 July 2020, Health Workforce Directorate issued guidance that was created to support staff and managers to carry out effective risk assessments on an individual basis. The guidance introduced was developed with Occupational Health Physicians and PHS. It was endorsed by the CMO and Clinical Advisors within Scottish Government. Senior Officials and Ministers were regularly updated due to emerging evidence. The guidance supported staff and managers to understand an individual's vulnerability to Covid-19 in relation to their job role, and is produced, (CL3/0105 - INQ000147427 and (CL3/0106 - INQ000147427.

361. The guidance available for staff and managers in Health and Social care included information on where staff could access support if they were affected by measures introduced regarding shielding, living with someone with a high-risk condition etc. This included information on sick pay, childcare / keyworker support, homeworking policies, wellbeing support services etc. The individual risk assessment encouraged a

supportive conversation between manager and employee, with clear information for staff on where to access support if they disagreed with their assessment.

362. Decisions were expected to be made in a non-discriminatory, supportive way. Managers were asked to ensure that staff had access to the right information and support to come to an agreed view of the level of vulnerability. We made it clear that staff members were not required to disclose medical details to their managers and that they should have sensitive, supportive conversations with staff that consider their health, safety, physical and psychological wellbeing, as well as personal views/concerns about risks. Wellbeing support services were also promoted to staff.

363. The guidance utilised the ALAMA occupational risk assessment tool to allow for an individual risk assessment to take place that could take multiple protected and personal characteristics into account. This tool was communicated to the c185,000 people on the Shielding/Highest Risk list to encourage its use amongst people for whom a return to the workplace could pose an increased risk (people at highest risk from Covid-19).

364. Prior to the individual risk assessment guidance (published in July 2020), there was interim guidance issued specifically for Health and Social care employers on staff from Black, Asian and Minority Ethnic backgrounds. Pregnant staff were directed to the Royal College of Obstetricians and Gynaecologists guidance. This is produced: (CL3/0106 - INQ000147439).

365. Self-isolation guidance for Health and Social Care workers reflected guidance for the general population and was available on NHS Info[1]rm until 23 July 2021 when exemptions for Health and Social Care staff were introduced. In the development of the self-isolation exemption guidance, consideration was given to 'at risk' and clinically vulnerable groups (both workforce and service users). Exemptions were allowed only on the basis of risk assessing both the individual and their deployment.

366. In the development of guidance to provide Health and Social Care staff discretionary access to FFP3 masks, known and perceived risks were taken into account, allowing an individualised assessment, including preference, to be considered. Evidence regarding NPI's from Health Workforce are listed within the document provided: *Covid-*

19 - Evidence - UK Covid Inquiry - Module 2a - NPI's Log - Final Version - 10 March 2023 (CL3/0145 – INQ000000000).

367. Public health and clinical guidance for social care settings provided advice on reducing person to person contacts. For example, in care homes it was recommended that social distancing be adopted as far as possible to reduce the risk of infecting residents and their carers and to reduce mortality. This was recommended in two ways: (i) reducing visitors to the home apart from essential visits; and (ii) social isolation in rooms as far as possible and reducing communal activity. Guidance also advised staff on social distancing within the home unless providing care. Examples of Scottish Government guidance containing advice on reducing contacts are provided.

- Clinical Guidance for Nursing Home and Residential Care Residents and Covid-19 (CL3/0107 - INQ000147440)
- Cabinet Secretary letter to Social Care Providers (March 2020) (CL3/0108 - INQ000147441).

368. For HPS / PHS public health guidance see:
- HPS Website - Information and Guidance for Social or Community Care & Residential Settings (scot.nhs.uk)
- HPS Website - Information and guidance for care home settings (scot.nhs.uk)
- Covid-19 Information and Guidance for Care Home Settings (1 May 2020)

369. Guidance was developed in May 2020 for the extended use of face masks and face coverings in hospitals, primary care, wider community care and adult care homes.

The Domestic Certification Scheme

370. Following the example of a number of other countries, Scotland introduced Covid-19 vaccine certification on 1 October 2021. Enforcement provisions did not come into force until 18 October 2021 to allow businesses time to prepare. The scheme applied only in a narrow range of settings – live events above a certain crowd size and premises open after midnight with music, alcohol and dancing. A paper setting out the key points about how the scheme would operate, (CL3/0109 - INQ000147442), was published on 9 September 2021, Parliament passed a motion approving the scheme on 9 September (CL3/0110 - INQ000147443). An updated paper, CL3/0111 - INQ000147444, that

provided more detail was published on 23 September 2021. To gain entry to a setting required to use certification, everyone attending had to be able to show they had been fully vaccinated with an approved vaccine (unless exempt) and that two weeks had passed for the vaccine to take effect.

371. Certification was to enable premises to be open but at reduced transmission risk by reducing (but not eliminating) the risk of infected people being present. Reducing transmission risk was beneficial in terms of reducing harm 1, while the premises were able to open when otherwise they might have been judged too risky given the need to keep overall transmission of the virus under control.

372. As stated in the Strategic Framework Update (November 2021) and in legislation, the aims of the scheme were to:

- reduce the risk of transmission of coronavirus
- reduce the risk of serious illness and death thereby alleviating current and future pressure on the National Health Service closure or more restrictive measures
- increase vaccine uptake.

373. Certification was required at a limited number of settings that were considered to be higher transmission risk:

- late night premises with music, which serve alcohol at any time between midnight and 0500 and have a designated place for dancing for customers
- indoor events (unseated) with 500 or more people
- outdoor events (unseated) with 4,000 or more people
- any event with more than 10,000 people.

374. Initially certification required evidence of vaccination. This was later amended to take effect in December 2021 to include a negative LFD test as an alternative to vaccination status. This alleviated some concerns for those who were vaccine hesitant.

375. In January 2022, following the EU change to the definition of fully vaccinated and after considering CMO advice, Ministers agree to add an expiry of 120 days since primary dose. A “booster” or a third dose was required to be defined as fully vaccinated. The status app was amended to take account of vaccination dates when displaying status.

376. The government's approach to certification was successful against a legal challenge in September 2021, prior to the scheme coming into force. The legal requirement for certification was lifted at the end of February 2022.

377. The Domestic Certification Scheme was a cross cutting policy led by the Covid Ready Society Division who set up a cross-government steering group to deliver advice to Ministers on Covid-19 Status Certification policy (domestic and international) by early June 2021. The group members brought intelligence from their respective roles and responsibilities on Covid-19 Status Certification to the Steering Group to ensure a shared understanding of developments in vaccination certification as this policy develops rapidly across technical, legal, ethical, equalities, international and domestic policy domains and which will enable consistency in policy advice to ministers.

378. The Terms of Reference are produced (CL3/0112 - INQ000147445).

379. Governance was later taken on by NHS NSS PMO to oversee delivery through a programme board. Links to the group terms of reference, membership, action log and meeting notes are provided.

The International Certification Scheme

380. The international certification scheme and app system was led by the Covid Ready Society Division. A summary timeline of the scheme is set out below:

381. February 2021 - Growing international interest in Covid Vaccine Certification as a tool to support international travel recovery. The Scottish Government initiated scoping work to develop a Certification scheme for international travel and domestic use. Some international travel companies started signalling the need for travellers to be fully vaccinated.

- March 2021 - Ministerial agreement to develop an App to give people access to their record of vaccination, for international travel, and to carry out further scoping on certification for domestic use.
- May 2021 - Ministerial approval to launch the interim solution for paper proof of vaccination from 19 May
- July 2021 -EU launched European Union's Digital Covid Certificate (EU DCC) scheme, citizens and residents will now be able to have their Digital Covid

Certificates issued and verified across the EU. Due to Brexit, Scotland and UK was not automatically part of the EU scheme. We needed to join as a third-party member.

- 30 September - 2021 NHS Scotland Covid Status App was released for international use. This contained two unique QR codes, one for each dose of the vaccine and since 13 January has included booster doses. This product was designed for use for international travel and domestic use.
- November 2021 - Scotland and rest of the UK formally adopted into the European Union's Digital Covid Certificate (EU DCC) scheme. All Covid-19 status certificates will be recognised across Europe. Scots travelling to the EU and countries covered by the scheme who had downloaded a PDF version with QR codes on their mobile device, or anyone who had a printed letter with their Covid-19 status dated before October 7 would need to either download the app or request a new letter.
- 18 March 2022 - all inbound travel restrictions were lifted in Scotland. There were no travel restrictions within Europe, but USA and a number of other countries have retained travel restrictions.
- The EUDCC scheme has a contract to July 2023 with the digital app provider. The EU may decide to extend the contract to continue providing a digital service beyond this period.

Local restrictions

382. As in other parts of the UK, restrictions were initially applied on a Scotland-wide basis in March 2020 and progressively relaxed over the summer, with specific measures implemented to manage local outbreaks. From October 2020 a system of geographically variable "Levels" was implemented. More detail on the levels system can be found in the DG Strategy and External Affairs corporate statement provided on 23 June.

383. Officials and senior clinicians from DG HSC were involved in the Level Assessments of 32 Local Health Authorities in line with Scotland's Strategic Framework including engagement with the relevant local authorities. This process was coordinated outwith DG HSC. Levels applied in each local authority area in Scotland from Monday 2 November 2020. Additional details can be viewed within Coronavirus (COVID-19): Scotland's Strategic Framework, produced, (CL3/0113 - INQ000147446).

384. This process also involved engagement with key stakeholders to inform decision making. The Directorate of Covid Public Health's engagement was coordinated with particular sectors (e.g., retail, transport, hospitality and economy) who may have been specifically impacted by changes ahead of the Strategic Framework updates. This was done through at least fortnightly meetings between internal stakeholders.

Working from home

385. The Framework for Decision Making from April 2020 was used to inform working from home measures and options that could be introduced, ensuring they were necessary, justifiable and proportionate.

386. From May 2020, policy officials within the Directorate for Population Health provided advice and guidance on various NPIs, including working from home to Constitution and External Affairs teams co-ordinating advice and policy on the matter.

387. Following the onset of the pandemic, DG HSC staff followed Scottish Government advice to work from home. The impact of this meant that online and hybrid meetings were encouraged to help prevent the spread of Covid-19. Hybrid meeting technology was installed in our corporate meeting rooms to support hybrid meetings.

Reduction of Person-to-Person Contact

388. This was a key population wide decision supported by a range of colleagues with DG HSC contributing. There were some specific issues where DG HSC led on coordinating including public health and clinical guidance for social care settings provided advice on reducing person to person contacts. For example, in relation to care homes, it was recommended to adopt social distancing as far as possible to reduce the risk of infecting residents and their carers and to reduce mortality. This was recommended in two ways: (i) reducing visitors to the home apart from essential visits, and (ii) social isolation in rooms as far as possible and reducing communal activity. Guidance also advised staff on social distancing within the home unless providing care.

The use of face coverings

389. Again, this was a key population wide decision made by Ministers collectively with support from DG HSC. DG HSC had a specific role in relation to development of

guidance for the extended use of face masks and face coverings in hospitals, primary care, wider community care and adult care homes.

390. Specifically on face coverings, there was cross-sector engagement to inform decisions on the mandated and guidance-based requirements. This included engagement on Covid-19 advisory sub-groups, such as education, on guidance to support implementation of requirements and to raise awareness and understanding.

Travel in and out of Scotland (including any consideration of the border with England)

391. As noted earlier, the Module 2/2A statement from the DG Strategy and External Affairs, provided to the Inquiry on 23 June 2023, sets out a detailed explanation of the approach taken to manage the importation of the virus, including restrictions and guidance on international travel to and from places outside the Common Travel Area (the UK, Ireland, the Channel Islands and the Isle of Man) and at times on travel within the CTA and Scotland. It explains that the border with England remained open for essential travel given, for example, the need for transport of food and medical supplies, as did the sea link to Northern Ireland. During periods of 'lockdown' non-essential travel was preceded by stay-at-home requirement. From November 2020 legal restrictions were in place limiting non-essential travel between Scotland and some or all of the CTA.

392. Scotland set various border measures on international travel to try to limit importation, particularly from countries where the virus was known to be at higher rates of circulation than in Scotland or where a new variant of concern was identified. The Scottish Government was committed to aligning on requirements on a four nations basis where possible. The liaison mechanisms used are set out in the Module 2/2A statement from the DG Strategy and External Affairs, provided to the Inquiry on 23 June 2023.

Repatriation

393. The Scottish Government were committed to repatriation on a four nations basis and worked closely with UKG and the other devolved administrations which included four nations and COBR meetings to ensure people were supported to return to the UK safely and securely, this was led by the Foreign, Commonwealth and Development Office (FCDO).

394. As repatriation and consular matters are reserved to the UK Government and specifically managed by the FCDO, we did not take 'decisions' during the Covid-19 pandemic on the repatriation of UK nationals. However, as the Scottish Government and Scottish Government Ministers were contacted by those who normally reside in Scotland about repatriation for themselves or friends/family, or by MSPs about individuals overseas, we sought to provide publicly available information to these individuals (sourced from UKG websites or the twitter feed of the local British Embassy/High Commission) and to pass on their cases to the FCDO case handlers who were dealing with cases raised by MPs and MSPs. Occasionally, Scottish Ministers would raise a specific case direct with an FCDO Minister or mention the need for better consular assistance regards repatriation during meetings with FCDO Ministers. (CL3/0114 - INQ000147347).

Consideration of the impact of NPIs on High-Risk Groups

395. The four UK CMOs agreed the criteria for the cohorts that they assessed may be most at risk of severe illness or death should they contract Covid-19 on 18 March 2020. These initial groups were as follows:

Group 1 – Solid organ transplant recipients
Group 2 – People with specific cancers
Group 3 – People with severe respiratory conditions
Group 4 – People with rare diseases
Group 5 – People on immunosuppression therapies which increases the risk of infection
Group 6 – People who are pregnant and have significant heart disease

396. Clinicians could also, based on their clinical judgement, add people to the Shielding list who were clinically at the highest risk from Covid-19 but were not included in the groups. If someone thought they were in the highest risk group but had not received a letter, Scottish Government advice was they should contact their doctor. If people were newly diagnosed, or if clinicians felt it was required, Scottish Government continued to add to the central list to ensure people could be supported to shield.

397. Throughout the pandemic, new criteria based on emerging evidence, data and clinical consensus resulted in additions to the Shielding List. On 30 October 2020,

people with Down's Syndrome were added to Group 4 of the Shielding List, and Chronic Kidney Disease Stage 5 (CKD5) was added to Group 5. CMO letters were sent to these individuals to notify them of this. In December 2020 the decision was taken to add people with liver cirrhosis to the Shielding List. In December 2021, approximately 9,000 people who were identified as severely immunosuppressed were added to the Shielding List (Group 5). These people, newly identified as being at highest risk, were not however asked to shield, as shielding in its most restrictive form was not returned to following the 'pause' on 1 August 2020.

398. Equality Impact Assessments: Due to the emergency nature of the introduction of Shielding as an NPI, an Equality Impact Assessment (EQIA) could not be carried out in advance of the policy being implemented. However, an interim EQIA of the support required by people who were at clinically highest risk of severe illness from Covid-19 (Shielding Programme) was carried out at the beginning of April 2020 and is produced. This highlights a range of ways in which people with protected characteristics may be negatively impacted by the Shielding policy. It also set out recommendations to mitigate these outcomes, or highlights where there were already mitigations in place. In November 2020, a retrospective EQIA was carried out as a follow up to the interim report from April 2020, produced (CL3/0115 - INQ000147447).

399. People who use drugs were not considered to be an 'at risk' group because of their use of drugs but many of these people were identified as being at risk for other reasons, such as being homeless or suffering from severe health conditions which made many individuals clinically vulnerable. Drug services in Scotland were continued throughout the pandemic as drug death levels in Scotland had grown significantly in the preceding years, with the highest proportion of drug deaths per population in Europe.

400. In reaching decisions on continuing services, including face-to-face contact services, for people who use drugs the Scottish Government worked with academics and people with lived experience through our Drug Deaths Taskforce to consider international and local evidence of harms associated with discontinuing treatment particularly around ongoing medication-assisted treatment. The Taskforce provided recommendations to Government on the need to continue access to treatment. This extended to making provision for mutual aid groups such as Alcoholics Anonymous to continue operating face-to-face where that was deemed essential and also extended to new arrangements being put in place for providing on-going access to daily administering of methadone where community pharmacies may have been inaccessible. The Scottish Government

also funded prison healthcare teams to switch opioid substitution treatment from daily methadone administrations to monthly injectable buprenorphine provision as a more pandemic-appropriate form of Opioid Substitution Treatment (OST).

The Test and Protect System – Impact Assessments

401. The Test and Protect system launched in May 2020 was led by the NHS in Scotland, and was a collaborative, multi-public agency partnership comprising PHS, territorial Health boards, NSS, the Scottish Government and Local Authorities. This included a significant partnership with the UK Government testing programme.

402. Test and Protect was anticipated to have a positive impact across all groups in society by reducing transmission of Covid-19 reducing deaths and serious illness caused by the virus. It was a fundamental part of the Scottish Government's strategy to mitigate the severe impacts of Covid-19 on public health and adapted as the pandemic progressed, scientific evidence on the nature of transmission of the virus emerged, and new technologies became available.

403. Policy decisions were underpinned by a wide range of sources including from PHS, the CMOs Directorate and discussions held at the four harms meetings; these considered how policy choices might best mitigate a range of harms (including the harm of the intervention itself) using sector specific evidence and other sources of information, for instance from higher risk settings, education etc.

404. Various iterations of testing strategy including purpose and scope of testing were developed over the period of the pandemic, (CL3/0116 - INQ000147448).

405. As the evidence base changed, the strategic approach and policy framework were reviewed to ensure that across all aspects of Test and Protect public health guidance and public health/health protection delivery were delivered in line with the latest evidence to provide an appropriate balance between the harms caused by Covid-19 and the potential harms of Test and Protect as an intervention.

406. On 17 March 2021. an Equality and Fairer Scotland Duty Impact Assessment, covering the three pillars that comprise Test and Protect: testing; contact tracing; and support for isolation was undertaken and published which set out the Scottish Government's assessment of the potential differential impact of aspects of Test and

Protect across groups with protected characteristics. This included an assessment of the differential impacts and potential harm caused by isolation guidance as an NPI on the range of groups with a protected characteristic. This is produced, Equality and Fairer Scotland Duty Impact Assessment (CL3/0117 - INQ000147449).

407. Having considered the potential differential impacts of isolation guidance, the Scottish Government implemented a range of services to attempt to mitigate the potential harm of isolation as an NPI including:

- The Self-Isolation Support Grant
- The National Assistance Helpline
- The Local Self-Isolation Assistance Service.

408. On 17 June 2021, the First Minister, Deputy First Minister and Cabinet Secretary for Education and Skills were provided with advice on the potential impact of isolation on children and young people including on educational continuity. The advice contained a wider discussion on the potential harms caused to this cohort by isolation, and is produced, (CL3/0118 - INQ000147450).

409. On 9 July 2021, Ministers were provided with advice and a draft contribution for a Cabinet paper which set out the equalities considerations of implementing the range of policy options provided. This is produced, (CL3/0119 - INQ000147451).

410. On 13 July 2021, a paper with policy options, produced, (CL3/0120 - INQ000147452), was provided to the Covid Education Recovery Group (CERG), an advisory group with membership including a wide range of child, young person and educational stakeholders as well as public health and clinical advisers, to seek an assessment and advice on the potential differential impacts on children and young people that would support an assessment for Ministers following.

411. Test and Protect was anticipated to have a positive impact across all groups in society by reducing transmission of Covid-19 reducing deaths and serious illness caused by the virus. It was a fundamental part of the Scottish Government's strategy to mitigate the severe impacts of Covid-19 on public health and adapted as the pandemic progressed, scientific evidence on the nature of transmission of the virus emerged, and new technologies became available.

<u>The initial development of Test and Protect</u>

412. The initial development of Test and Protect (assumed to cover the period up to the end of May 2020) was first shaped by the UK Influenza Pandemic Strategy 2011. The UK Government, in collaboration with the Scottish Government, Welsh Government and Northern Irish Executive, developed the UK Influenza Preparedness Strategy 2011, which aimed to reduce the impact of a potential influenza pandemic on the population by:

- stockpiling antiviral drugs
- increasing laboratory capacity
- promoting vaccination
- identifying and isolating cases
- promoting good hygiene practices.

413. This strategy provided a general framework for responding to pandemics. As health is devolved in Scotland, the Scottish Government took account of this strategy when developing its own strategy to respond to Covid-19.

414. As scientific understanding of the virus increased, so did the overall strategy. Testing technology was quickly developed but it took time to build testing capacity – both sampling capability and lab capability. SAGE advice was a key influence in deciding priorities for the future Test and Protect programme and on 27 February 2020 listed its key priorities as:

- detect and monitor any outbreak as effectively as possible
- understand effective actions to help contain a cluster
- understand measures to alter the shape of a UK epidemic
- model UK epidemic and identify key numbers for NHS planning
- understand risk factors around demographics, geographies and vulnerable groups (for example age)
- generate behavioural science insights for policymakers
- ensure NHS trials key interventions
- consider emerging therapeutic, diagnostic and other opportunities

415. SAGE met for a fourth time on 4 February 2020. It discussed the Scientific Pandemic Influenza Group on Modelling, Operational sub-group (SPI-M-O) Consensus statement which analysed the potential impact different interventions could have, and

states that: "[contact tracing] is critically important in early cases to gain an understanding of disease dynamics, particularly to answer questions about transmission, including asymptomatic transmission. We do not know what the impact of contact tracing would be on delaying the epidemic in the UK. Contact tracing is not practical once there are large numbers of cases. It also has a high opportunity cost." SAGE agreed that:

416. greater data sharing on the outbreak was essential, and delaying the arrival of the virus in the UK would be beneficial to improve NHS readiness,

- based on the current evidence, domestic measures such as shutting down public transport or restricting public gatherings would probably be ineffective in creating a meaningful delay in the spread of the virus, and,
- the UK should continue to plan using current influenza pandemic assumptions, which can be modified as data becomes more certain.

417. On 24 January 2020, Covid-19 diagnostic testing commenced at the London-based Colinton laboratory as a WHO reference lab. On 30 January 2020, the UK's first two positive cases were confirmed in England in two Chinese nationals staying in York.

418. On 10 February 2020, two labs opened in Scotland to ensure more rapid turnaround of testing in Edinburgh (100 tests a day) and Glasgow (250 tests a day). Initially positive cases still needed to be confirmed at the reference lab in Colinton.

419. On 1 March 2020, Scotland's first positive case was confirmed. Shortly after on 3 March 2020, the UK-wide Coronavirus action plan was published, which provided the public with information on plans to contain the virus, how action will develop as the virus spreads, and what people can do to protect themselves and their families. It contained information on the government's 4-stage strategy to contain, delay, research and mitigate. The document focussed on identifying and isolating being essential to the contain and delay phases. If the UK were to move to "mitigate", "there will be less emphasis on large scale preventative measures such as intensive contact tracing. As the disease becomes established, these measures may lose their effectiveness and resources would be more effectively used elsewhere". On 11 March 2020, the first case of community transmission in Scotland was confirmed.

420. On 13 March 2020, the locally led 'test, trace' isolate' intervention was paused for the general public as all symptomatic people are advised to stay at home for seven

days regardless of travel and contact. Testing the general public stopped but is maintained in hospitals for admissions with suspected Covid-19, and all ICU admissions with upper respiratory related conditions, for the purposes of clinical care and diagnostics. This follows advice from the four nation CMOs on 12 March 2020.

421. On 23 March 2020, the CMO recommended that Ministers extend testing to allow key workers to exit isolation and return to work. Ministers agreed to this proposal. The UK Government announced an investment to support the work of the Covid-19 Genomics UK consortium.

422. On 25 March 2020, Ministers are provided with the legal assurance for Scotland to be able to join the UK lab testing programme, following in principle agreement on 22 March 2020.

423. On 27 March 2020, a four nations Ministerial call was held, which included discussions on testing. The discussion centred on testing capacity, which was not just a question of increasing lab capacity but also of increasing sampling capacity. The meeting also mentioned the first drive-through regional test site in Glasgow and plans to establish a home test kit ordering service.

424. On 29 March 2020, the First Minister agreed to CMO request to deliver a Scottish Covid-19 Testing Strategy that brings together all testing activity relevant to Scotland, and to the creation of a Scottish Testing Oversight group, with a remit to oversee the Scottish COVID-19 Testing Strategy.

425. On 30 March 2020, the First Minister's office wrote to the CMO to say that in additional to the three objectives for testing (serious illness, key workers, surveillance) another should be added, to consider the role of testing as capacity expands to come out of suppression measures – moving back to test, trace, isolate on a bigger scale

426. The Testing Strategy Oversight Group first met on 1 April 2020. It identified six workstreams to develop the strategy, identify links across the testing system and maximise the testing Scotland is able to do. The group met three times per week and its six workstreams were:

- Strengthening laboratory testing by increasing NHS laboratory capacity, and supporting and participating in the UK programme to deliver large-scale non-NHS testing to people in Scotland
- Developing antibody testing
- Supporting surveillance, epidemiology and prioritisation, including forward look to anticipate changes in testing approaches as we exit the suppression stage
- Managing data and maximising quality of data management
- Logistics and access to testing
- Communications.

427. On 23 April 2020, the Scottish Government published Covid-19 Framework for Decision Making which set out the role of testing, contact tracing and isolation as part of transitioning out of lockdown.

428. On 4 May 2020, the Scottish Government announced the Test, Trace, Isolate, Support Strategy (TTIS) – testing those with Covid-19 symptoms, tracing their contacts, and supporting people to isolate. The strategy highlighted action underway to operationalise the programme, and the five steps for the measures to be an effective public health intervention:

- Effective disease surveillance. We need to understand Covid-19 in Scotland and identify patterns in disease activity, such as local outbreaks.
- Early identification and isolation of possible cases. We need everyone to be aware of the symptoms of Covid-19 and understand what they need to do themselves to support our "test, trace, isolate, support" approach.
- Early and rapid testing of possible cases. We are working towards ensuring that everyone who needs a test can get one, regardless of whether they can travel to a drive-through test centre, need to be seen by a healthcare professional, or can self-administer a test at home.
- Early and effective tracing of close contacts of a confirmed case. This will involve people providing information about who they have been in close contact with, supported by dedicated staff as required and technology where appropriate. This process may start before the person has their test result.
- Early, effective and supported isolation of close contacts. Chains of transmission can only be broken if those who could transmit the disease to others are isolated and get the support, they need to maintain that isolation.

429. On 5 May 2020, Scottish Ministers received advice on the operationalisation of the Test, Trace, Isolate, Support (TTIS) Strategy and Caroline Lamb was appointed as TTIS Delivery Director. On 28 May 2020, operational service for TTIS was launched following publication of the Test and Protect strategy.

430. From this period various iterations of the testing strategy were developed and implemented under the overall strategic direction as set by the Framework for Decision Making.

431. The transition out of population wide test, trace isolate policies towards the end of the emergency phase of the pandemic was set out in the Test and Protect Transition Plan (CL3/0121 - INQ000147346).

Shielding – Impact Assessments/Equalities

432. On 15 July 2021 the four nations CMOs reviewed evidence presented by the UKG on the risk to children and young people from Covid-19. Professor Nicola Steedman attended for Scotland in place of the CMO. The meeting decided that all children and young people under 18 should be removed from the Shielding/Highest Risk List, on the basis of extremely low rates of serious disease or mortality in this age group. The evidence noted that a small number of children could still be advised by their GP or hospital clinician to take extra precautions, just as they would have done to protect themselves pre-pandemic, but there would no longer be any central shielding advice for children and young people and that they should be removed from the Shielding/Highest Risk List. Based on this clinical decision, Covid Highest Risk colleagues communicated this recommendation and the evidence supporting it to the Cabinet Secretary and First Minister, seeking approval, comments and direction regarding this process and its associated communications.

433. Ultimately it was decided by the Cabinet Secretary and First Minister to not remove children and young people from the Shielding/Highest Risk List (HRL) at that time. This was due to the high rates of Covid at the time in Scotland and it was considered an inopportune time to announce this measure, as it could be seen as confusing and contradictory to public health messaging. There was also no perceived risk or detriment to keeping children and young people on the HRL as a result of this decision.

434. Officials engaged and sought advice from PHS, the National Incident Management Team (NIMT) and Scientific Advisory Sub-Group on Education and Children's Issues (SASG) that provided advice to the Covid Education Recovery Group (CERG)

435. The Shielding/Covid Highest Risk Division was closely involved with providing advice to colleagues on guidance for early learning settings, schools and further education, workplaces, and prisons, as well as targeting specific professional or advisory areas. Covid Highest Risk division organised or contributed greatly to forums which sought to draw together these areas of expertise. As mentioned in response to PA-9 these groups included Local Authorities, Voluntary and Third Sector, Medical Organisations/charities, COSLA, NHS, Education, the Clinical Leads Advisory Group for Scotland (CLAGS) and Resilience Partnerships. This helped to provide a greater understanding of the impact of the pandemic on those cohorts but assisted in decisions and advice designed to support those people with greatest need. In addition to the EQIAs described in the answer to PE-73-A, the Shielding/Covid Highest Risk division contributed to EQIAs in relation to updates to the Scottish Government's Strategic Framework. This ensured that consideration was given to any potential impacts of changes to restrictions/guidelines that may affect those people with protected characteristics on the Shielding/Highest Risk List, (CL3/0122 - INQ000147453).

436. In addition to the Equalities Impact Assessments that were carried out, we carried out Children's Rights and Wellbeing Impact Assessments, Data Protection Impact Assessments and Business and Regulatory Impact Assessments. These were all published. We carried out stakeholder engagement, including with those representing protected characteristic groups.

437. February 2022 - The Shielding Division contributed to EQIAs in relation to updates to the Scottish Government's Strategic Framework updates. This ensured that consideration was given to any potential impacts of changes to restrictions/guidelines that may affect those people with protected characteristics on the Shielding List.

Response to "super-spreader" events in Scotland between January and March 2020

<u>The Nike Conference</u>

438. The Nike Conference took place in Scotland from 25 to 27 February 2020. The first case of Covid-19 confirmed in Scotland was not until 1 March 2020. On that date, there

had been no positive cases in Scotland linked to the conference. Health Protection Scotland (HPS) were alerted on 2 March 2020 that an individual who was now overseas, but who had been at the conference, had tested positive. On 3 March 2020, HPS recorded a positive case in Scotland of an individual who had been a conference delegate. That case and the details of the potential outbreak was confirmed to Scottish Ministers on the evening of 3 March 2020. Details of that case were then included in a news release issued on 4 March 2020 and included in the Scottish Government's normal case reporting schedule.

439. Twenty-three primary cases were linked to the conference and 16 secondary cases were subsequently identified. HPS led on the management of this outbreak which included an International Incident Management Team (IMT), and they subsequently undertook an assessment of this, providing a detailed report on 5 October 2021. This concluded that following Whole Genome Sequencing (WGS) of the severe acute respiratory syndrome, coronavirus 2 (SARS-CoV-2) virus identified a particular sub-lineage B-S16 associated with the conference. Sub-lineage B-S16 has not been detected in Scotland since April 2020. They concluded that the '…WGS results strongly suggest that the actions taken by the incident management team (IMT) to manage the outbreak were successful in curtailing onward transmission.'

440. The decision making on the Nike event was led by HPS, NHS Lothian and Edinburgh City Council, CMO and officials from the Health Protection team (which became Covid-19 response Team). An IMT was established and led by HPS, which included representatives from Scottish NHS Boards, NHS Lothian, West of Scotland Specialist Virology Centre (WoSSVC), Public Health England and PHE National Incident Coordination Centre (NICC).

441. An IMT report on the Nike conference outbreak was published in October 2021, and produced, (CL3/0123 - INQ000147454).

Super-spreader events

442. In advance of the 'lockdown', the risk around particular events were discussed primarily in SGoRR meetings. This included the Cheltenham Festival 10-13 March 2020, and Six Nations Rugby including Scotland v France 8 March 2020.

443. The advice was based on the very best evidence we had at the time and discussed through the governance in place at the time, covering both health protection operational oversight (through IMT) and also policy oversight through both SGoRR O and SGoRR M (Officials and Ministerial).

444. The Covid-19 Advisory Group (C19AG)'s advice on Physical Distancing and Superspreading was published on the Scottish Government website. The group was advisory, and considered papers produced by World Health Organisation (WHO) and other international organisations. However, they did not have a decision-making role. They produced advice on superspreading events on 2 July 2020, this advice was commissioned by the First Minister and Chief Medical Officer. A copy of this advice is produced.

445. CMO also provided advice following discussion between the four CMOs. HPS also provided advice. This was before CRS came into existence. The advice was based on the best evidence at that time and discussed through the governance in place at the time, covering both health protection operational oversight (through IMT) and also policy oversight through both SGoRR O and SGoRR M (Officials and Ministerial). This was within Population Health timeframe before CRS came into existence,

Border with England

446. In the early stages of the pandemic, the border with England was discussed, but only in terms of there being less strict measures in place in England and therefore a likelihood that there would be spread of the virus over the border. The impact of the border was also discussed in terms of complexity/simplicity of messaging when there were different rules in place in the different countries. As noted earlier, more detail on border issues is in the DG Strategy and External Affairs statement issued on 23 June 2023 that describes the guidance and restrictions that the Scottish Government put in place from the autumn of 2020 to limit travel between Scotland and places in England and elsewhere in the Common Travel Area with high prevalence of the virus. It also describes the restrictions implemented to limit travel between areas of low prevalence and high within Scotland.

447. In terms of the Scottish Government's face covering policy, over the course of the pandemic, there were differences with the rest of the UK/England - such as providing a physical exemption card, retaining legal requirements longer, and continuing to

'strongly recommend' the wearing of face coverings. There was some consideration given to this when people were travelling across UK which was addressed through guidance.

448. In relation to isolation guidance, whilst it was a factor considered as part of decision making (for instance, to consider the complexity of messaging) it was one factor along with the impact on individuals of isolation, the clinical perspective from the Chief Medical Officer, public health input from Public Health Scotland clinicians and the wider pandemic and societal circumstances at the point key decisions were being made.

449. In terms of domestic certification, consideration was given to an app which could be used in a domestic setting for specific events, including cross border events.

Divergence

450. All officials and advisers in DG HSC were mindful of points of divergence and alignment between UK nations across a wide range of policies and delivery mechanisms throughout the pandemic. Divergence and alignment had different causes including legal, geographic, demographic. Decisions of the UK Government in particular on funding, procurement, UK wide services such as population testing and vaccinations, and reserved policies such as international travel impacted on the Scottish Government's response to the pandemic. More detail on divergence is in the DG Strategy and External Affairs statement provided on 23 June 2023.

451. The definition of clinically extremely vulnerable (CEV) was decided in unison by the four nations CMOs at the beginning of the pandemic. The approach to further develop the list of people at highest risk (referred to as 'clinically extremely vulnerable' in UKG) did, however, vary slightly across the UK - Scotland, for example, did not apply QCovid to population records in Scotland, however, findings in England from use of QCovid such as the identification of vulnerability in people with Downs' Syndrome and people with chronic kidney disease resulted in these groups being added to Scotland's list. Scotland did not use QCovid for clinical decision-making, for clinically vulnerable group vaccine prioritisation in January 2021 - when Scotland's Shielding List itself was used as a proxy, or for the Shielding List update in February 2021, when UKG added approximately 1.7m people to its CEV list.

452. It was decided not to use QCovid in Scotland due to:

- Data gaps in the earlier iterations of the QCovid model
- Evidence on which QCovid was based not accounting for protection from vaccination
- QCovid not taking account of new emerging variants
- The policy decision not to ask people to shield again in Scotland after 31 July 2020
- QCovid not being compatible with Scottish data structures (such as CancerCare records, or different measures of deprivation)
- The requirement for separate validation of the model for the Scottish population.

453. In some instances, there was divergence in the support and advice given to those considered highest risk of Covid-19. For example, the UK Government ended their Clinically Extremely Vulnerable list in September 2021, before the Scottish Government ended the Highest Risk List on 31 May 2022. People on Scotland's Highest Risk List were provided with additional levels advice from October 2020 and were given updates and guidance in relation to Scottish Government policy throughout. This advice aligned with the 5 Levels system adopted by Scotland. It is worth noting Scotland's advice to those on the Highest Risk list from August 2021 to 31 May 2022 was to follow the same advice as the general population, unless advised otherwise by their GP or specialist clinician.

Herd Immunity

454. A summary of the Scottish Government's considerations toward herd immunity as a potential means of responding to the pandemic is set out in the Module 2A Expert Health Entities, provided to the Inquiry on 23 June 2023.

Public health communications in Scotland during the Covid-19 pandemic

455. The Scottish Government corporate communications team leads on all internal and external communication, working closely with communication leads in the other governments, executive agencies, statutory responders and key resilience partners. Further information on the role of corporate communications during the pandemic is provided within the Module 2/2A DG Corporate statement provided to the Inquiry on 23 June 2023.

456. A full timeline of material published by SG, including press releases, throughout the relevant time period, has been made available to the Inquiry as part of the Module 2/2A

DG Corporate statement provided to the Inquiry on 23 June 2023. The Module 2/2A DG Strategy and External Affairs statement provided to the Inquiry on 23 June 2023 describes the comprehensive guidance that was published for the general public and for businesses and other organisations.

457. When officials are notified by PHS or by other public bodies of an incident or outbreak, the Health Protection Division take immediate responsibility for ensuring relevant policy areas, clinicians and communications leads within the Scottish Government, and where relevant Scottish Ministers, are aware of all the issues and are prepared to act as necessary.

458. During the specified time period the Scottish Government and HPS liaised closely during incidents. However, it was HPS, as public health experts, which led on communication with the public about high-consequence infectious diseases. Advice was also provided on NHS Inform. In addition, the Scottish Government, represented by the CMO, DCMO, Senior Medical Officers or the NCD often provided further communications to media requests. This was in the form of reassurance and explanations where necessary.

459. In all scenarios, the Health Protection Team worked to ensure both the Scottish Government and PHS communications were connected and that all messaging aligned in the public interest. Where the Scottish Government's communication lines were put forward, the Health Protection team sought clinical input from the CMO's team and other policy areas as required.

460. The Scottish Government's precise role in public facing communications varied, depending on the circumstances of the nature of the incident. Some communications were best dealt with as a purely clinical matter for HPS, in which case the Scottish Government's voice could have caused unnecessary confusion or undermine messaging. In other situations, proactive or reactive communication lines were required with the management of logistics including the availability of HPS and Scottish Government experts. HPS Management of Public Health Incident guidance on roles and responsibilities sets out the relationships, (CL3/0124 - INQ000147455).

<u>Effect of different messaging by the UK Government</u>

461. In general, as the pandemic developed our approach and messaging did differ at times from the UKG. For example, when the UKG added 1.7 million people to their Shielding/Clinically Extremely Vulnerable list as a result of their decision to deploy the risk stratification tool QCovid, attempts were made by Shielding colleagues to ensure this wouldn't be confusing for the Scottish population. We liaised with UKG counterparts to check what they were planning to say around this and to try to minimise confusion for the Scottish population. Proactive media lines were created to explain that SG was not going to do the same and to explain the reasons why. This was also included in a CMO letter to the list of individuals in Scotland.

462. There was also Scotland-specific messaging in relation to the face covering exemption card scheme in that Scotland implemented a physical card option from inception which was communicated alongside messaging to ensure people were treated with kindness if they were unable to wear a face covering. This messaging was also relayed via our delivery supplier, Disability Equality Scotland, on behalf of Scottish Government.

463. For the Shielding/Covid Highest Risk Division, there were also Scotland-specific issues that were the subject of public health messaging, specifically:

- Changes to Protection levels, on a Scotland-wide and Local Authority basis and what this meant for people at highest risk from Covid-19, and
- Updates to Scotland's Strategic Framework and what this meant for people at highest risk from Covid-19.

464. Our public health messaging on these matters was issued in a number of ways. Firstly, CMO letters to the highest risk cohort, which were drafted by Covid Highest Risk Division in the first instance, with relevant clinical input from CLAGS, the DNCD John Harden, and amended as required by the CMO's office. The letter would then be sent out in the CMO's name to those on the shielding/highest risk list.

465. Secondly, by our SMS alert service to the Shielding/Highest Risk list (for those who signed up for it). This service was operated by NHS Education for Scotland (NES) and the content of the messages created by the Covid Highest Risk Division. A record of our public health messaging/communications in the form of CMO letters and SMS alerts is produced, (CL3/0144 - INQ000147456). Content specific to people on the Shielding/Highest Risk list was also included in FM's regular briefings – we knew from research amongst this group that these briefings were the main source of information

and guidance. Additionally, there were pages specifically for people at highest risk from Covid-19 on mygov.scot and gov.scot.

Public Health Communications and Vaccinations

466. As in the other UK nations, the Vaccinations Division adhered to the guidance of the JCVI, although the vaccination programme was at times delivered at a different pace in Scotland to other devolved nations. In these instances, Scotland-specific public health messaging was necessary to ensure that the general public had the most up-to-date information

467. As part of this programme, it was identified that the programme lacked security coordination and FVCV set up an initial short life working group (SLWG) in December 2020 to coordinate security activities with stakeholders. This SLWG became a full programme workstream in summer 2021. Part of the FVCV Security Workstreams remit was to maintain and share awareness of Covid-19 vaccine related health mis and disinformation. This was achieved throughout the pandemic by liaising with the UK Department of Health and Social Care's UK Covid Vaccine Security Group (UKCVS) who were coordinating actions nationally in response to anti-vaccination activity on a UK level, recognising that such activity cuts across UK and international boundaries.

468. The UKCVS maintained a broad security overview on issues which could reduce the effectives of the UK Vaccine programmes, which included Dis/Misinformation. This shared information and awareness successfully assisted the FVCV Security workstream in actively alerting NHS Boards and other stakeholders to anti vaccination activity in their area (such as leafletting, posters and online activity) to allow any threat to staff and patients be mitigated.

469. In line with international best practice, the FVCV Security workstream chose to not directly engage with anti-vaccination individuals on social media, preferring to point the public to reliable sources of information such as NHS Inform and the Scottish Government website. The same approach was used by Scottish Government Social Media channels. The FVCV workstream did however communicate directly with health boards as well as with directors of education to inform them about anti-vax/misinformation campaigns targeted at health professionals or education providers, to explain why the contents of these campaigns are false and provide them with reassurance.

470. In September 2022 an agreement was made that DHSC UKCVS would transition to the HSA which would include elimination of any duplication of functions between these bodies, and an integration board was set up. Since that time the UKHSA has led on countering disinformation.

471. Some practical tasks for countering harmful health disinformation led by the Scottish FVCV Security group itself have been:

- Producing online training for Vaccination Centre staff on staff safety and conflict de-escalation and social media safety for vaccine centre staff
- Publicising ongoing security reminders in the weekly FVCV Operational Bulletin for NHS staff awareness
- Organising a webinar for FVCV Security stakeholders such as NHS and Local Authority staff on Fake News and Disinformation awareness
- Providing advice, guidance, and support to vaccination staff on the ground relating to the distribution of disinformation and in person protest.

472. Although Covid Highest Risk Division never directly indicated that we were countering disinformation with our messaging, all Shielding/Highest Risk List communications set out the true clinical and government position. For example, we made clear in our communications the evidence to support people on the Highest Risk List receiving their vaccination to counter disinformation circulating about its safety and efficacy.

473. We also shared information with stakeholders such as Local Authorities to help support the sharing of clinically correct advice/communications around vaccination for people on the highest risk list via the National Assistance Helpline. The Covid Highest Risk Division created, and shared with local authorities, a National Assistance Helpline Vaccine Q&A document, which was regularly updated. An example Local Authority Q&A Vaccine of 18th January 2021.

474. On 7 May 2021, the JCVI published an announcement, (CL3/0125 - INQ000147457), following findings by the MHRA that the AstraZeneca vaccine in use at that time was associated with (extremely rare) cases of thrombosis/thrombocytopenia, recommending the AZ vaccine not be used for those aged under 40.

475. Evidence associating vaccination with (again extremely rare) cases of heart inflammation (myocarditis) among children under the age of 18 was also cited by the JCVI in its advice, (CL3/0126 - INQ000147458), recommending the vaccination of 5 to 11-year-olds on 22 December 2021.

476. The association of vaccinations with certain rare health conditions may have harmed public confidence in the vaccination programme, and particularly the AZ vaccine. Additionally, vaccination adverse incidents, such as mis-vaccination or allergic reactions, while unavoidable given the scale of the programme, often gained media attention, and may have damaged public confidence in the programme.

Healthcare staff communications

477. An internal NHS campaign "Kind to Remind" was launched on 24 May 2021 to encourage Healthcare Staff to follow infection, prevention and control (IPC) measures when they were in non-patient facing areas. The aim of the campaign was to reduce the spread of nosocomial Covid-19 between healthcare workers (HCW) in staff only areas. Non-patient facing areas such as staff rooms, canteens, corridors etc. were identified as areas of higher transmission risk. This communications campaign included a short film, posters & digital assets which were sent to Boards to use internally in staff areas. In order to avoid causing undue concern for patients and service users the campaign was not shared on SG social media or in patient facing areas.

Evaluating Public Health Communications

478. Polling has been used to monitor public compliance and response to protective measures. Website hits were also used to evaluate how many times a webpage has been accessed. As all DG HSC communications, these are under Scottish Government and not DG HSC headings.

479. However, CRS in their lead role for the Face Covering exemption card scheme, monitored specific feedback and communications from the public and stakeholders via the supplier relationship with Disability Equality Scotland (DES), who administered the scheme. The communication on the scheme was integrated into wider SG communication channels, however, there were regular surveys carried out by DES with members of the public via mail and social media to analyse feedback and the use of

the scheme. These were provided to the Scottish Government through reporting and used by the policy team to help inform any changes to our messaging, communication and delivery of the scheme.

480. For public health messaging for those on the Shielding/Highest Risk list, we carried out pre-testing for most of our key communications. For example, usability testing was carried out for our Text Alert Service, 'Everyday Activities' Personal Risk booklet and key CMO letters (new additions letter and ending of the HRL). This involved working our way through the documents with a selection of individuals from the HRL and noting any feedback they had around aspects of the communications they found confusing or poorly worded/presented. This feedback was then used to make the appropriate changes before the communications were sent to the wider HRL. We also knew from the PHS Shielding evaluation survey, produced, (CL3/0127 - INQ000147459), that some people found the first CMO letters frightening. Whilst this was to an extent necessary given the nature of the crisis facing this group, we acted on this feedback and softened and simplified the language in subsequent CMO letters.

481. On 31 July 2020, the Shielding division officially paused the policy for people on the Shielding List to strictly self-isolate at all times. It then carried out user research in July 2020 in the form an online survey to find out:

- People's experiences of shielding as measures eased
- Impact of shielding measures on the mental health of people who were shielding
- Information needs for people shielding as measures eased.

482. 3,033 survey responses were received from people who were shielding. Key findings from this survey indicated continued high levels of anxiety and fear about catching Covid-19, concern that guidelines were not being followed by the rest of society, and that the shielding group felt forgotten. This shaped our ongoing communications strategy to continue to support this group and provide timely and helpful information and advice for as long as it was necessary.

483. For the Testing and Contact Tracing Division, in 2021 Ministers commissioned a social research study to assess experiences and behavioural outputs of engagement with Test and Protect to better understand, for instance, Scotland specific levels of compliance with isolation guidance. This study is produced, (CL3/0128 - INQ000147424). The ScotCen report concluded that, "Awareness, across all case types, of the requirements for positive cases to isolate for 10 days and for a close

contact to isolate for the same length of time (even if they later test negative themselves) suggests that the messaging around these requirements has been largely effective".

Errors in messaging and corrections

484. An SMS was sent by NES on the Scottish Government's behalf on 5 October 2020 to those on the Shielding List who had signed up for text messages from SG with an incorrect URL (a full stop was included). To rectify this, a follow-up text message was sent out apologising and with a new URL on the 6 October 2020. We are not aware of any negative consequences arising from this error.

485. On 20 January 2021 an SMS was sent to the HRL which included information about vaccinations for people on the HRL. The SMS sent read: "As someone who is on the shielding list, you will be offered your first coronavirus vaccine dose by mid-February. Your NHS health board or GP will contact you soon. You do not need to do anything in the meantime. We are prioritising people for the vaccine based on their risk of serious illness if they catch coronavirus. If you are 80 or over, you will be offered the vaccine by 5 February. Find out more about the vaccine at".

486. Feedback received from parents of people under 16 indicated that it was unclear whether this group were eligible, and so a further SMS was sent on the 22 January 2021 to clarify the position. The follow up SMS read: "Please note that the advice we gave in our text to you on Wednesday regarding vaccination only applies to people aged 16 and over. To clarify, children and young people under 16 on the shielding list can only be vaccinated under exceptional circumstances after an individual risk assessment by their clinician. Apologies for any confusion this may have caused.". Local authorities were also briefed immediately when this issue arose to ensure any calls to the National Assistance Helpline on this point could be addressed.

487. When adults with Down Syndrome were added to the Shielding List, an issue arose when approximately 30 people who didn't have the condition were identified by PHS and sent a shielding letter on the 30 October 2020. This was not an error by PHS as the code for Down Syndrome appeared in the individuals' hospital record. We removed the individuals concerned from the Shielding List (and sent letters of apology) as soon as they notified us of the issue (early November 2020).

488. Two users of the SMS alert service reported to us that they received phishing text messages which purported to be part of the Shielding service in which there was a link to a fraudulent HMRC site which asked people to put in their bank details. In response the SMS service (run by NES) checked for security breaches and put out a message to all recipients at SG's request with the following, which was also added to our mygov.scot/shielding pages: "The Scottish Government will never ask you for sensitive personal information or your banking details. If you receive a suspicious text message, you can report it by calling Police Scotland on 101."

Behavioural Management

489. There was no official commission of behavioural management for the Shielding/Covid Highest Risk Division's public messaging. However, our communication strategy and outputs were founded on the basics of behavioural science. We used the COM-B behavioural model (Capability, Opportunity, Motivation – Behaviour) to inform communications to people on the Highest Risk List via CMO letters and MyGov content.

490. The Covid Highest Risk Division occasionally consulted with Professor Steven Reicher and Professor Linda Bauld on an informal basis. Both Prof Reicher and Prof Bauld attended virtual calls with our division to share with us the benefit of their expertise and to answer questions in relation to the approach the Covid Highest Risk Division were taking to protect people at highest risk. An example included the wording of CMO letter and text messages aimed to motivate people by giving them a strong reason why they should do something, and empowering and enabling people to take action to protect themselves and others.

491. For the Testing and Contact Tracing Division, whilst no behavioural management advice was commissioned specifically, views on the potential impact of policy options and public messaging on collective behaviours were provided through, for instance, the Covid-19 Compliance Programme which included a member who is an academic specialising in group and collective psychology. This group was coordinated and led by the Covid Coordination Directorate with DG Strategy and External Affairs

The Scottish Government's proposals for public health and Covid-19 legislation and regulations

492. The the DG Strategy and External Affairs statement issued in on 23 June 2023 (Ref: M2A-SG-01) and DG Strategy and External Affairs legislation statement issued 23 June 2023[(Ref: M2A-EJD-02) set out detail of the various primary and secondary legislation promoted and made by the Scottish Government in relation to Covid-19. Throughout the period relevant to this statement teams across DG HSC contributed to the development of such legislation.

493. The guidance to shield given to those considered at highest risk in March 2020 was not enforced by law and therefore did not form part of the public health and Covid-19 legislation and regulations. The guidance to shield was provided as advice only. Shielding was referred to in legislation in the Statutory Sick Pay (General) Regulation 1982 as amended. However, these regulations are UK regulations and a reserved area for the UKG, therefore DG HSC involvement would have been consultative at most.

494. The Health Protection (Coronavirus) (Restrictions) (Scotland) Amendment (No. 11) Regulations 2020 (SSI 2020/241) (the Regulations) were made by the Scottish Ministers under paragraph 1(1) of schedule 19 of the Coronavirus Act 2020 (the 2020 Act) and laid before the Scottish Parliament 13 August 2020. The Regulations came into force, Friday 14 August 2020.

Test and Protect Legislation

495. The Coronavirus (Discretionary Compensation for Self-Isolation) (Scotland) Act 2022 (the 2022 Act) modified the Public Health etc. (Scotland) Act 2008 (the 2008 Act) so that the duty to pay compensation to people asked to, for instance, stay at home or not attend work in relation to suspected or confirmed coronavirus was changed to being a discretionary power.

496. The Bill that became that Act was introduced because the modification of the 2008 Act in the Coronavirus Act 2020 was due to expire as the UK Government took steps to repeal that emergency legislation.

497. Scottish Ministers agreed that the modification was still required and introduced the Bill to Parliament on 15 November 2021. The rationale for this was that if the temporary modification to the 2008 Act was to expire, it would place a significant administrative and financial burden on Health boards. Alternative financial support, including that

provided by the Self-Isolation Support Grant for people earning the real living wage or less, remained in place.

498. Ministers agreed that the 2022 Act could expire on 31 October 2022 because wider circumstances and public health guidance had changed, mitigating much of the financial risk on Health boards by the modification to the 2022 Act expiring.

Recovery Planning

Mobilisation and Remobilisation Plans 2020-2022

Remobilise, Recover, Re-design: the. framework for NHS Scotland (published in May 2020)

499. The 3 R's Framework – 'remobilise, recover, re-design' was developed through engagement with policy, service, and Ministerial stakeholders during spring 2020, and is produced in paragraph 167: (CL3/0051 - INQ000147375). A series of seminars also led to the Covid Recovery Strategy: for a fairer future being published. An example of the seminars is produced, (CL3/0129 - INQ000147415), as is the *Covid Recovery Strategy: for a fairer future* (CL3/0134 - INQ000131075).

500. Andrew Fleming, Interim Deputy Director of Territorial NHS Board Sponsorship (2019-2021) led on the development of the Framework. The Framework set out how NHS Boards would safely and incrementally prioritise the resumption of some paused services, while maintaining Covid-19 capacity and resilience. It was the responsibility of NHS Boards to use the Framework to develop remobilisation plans. SG held NHS Boards to account on remobilisation through the operational planning process. The Operational Planning team (now the Health Planning and Sponsorship Team) led on the commissioning of local mobilisation and remobilisation plans from the Territorial Health boards. These plans were intended to lay out how the Boards were going to mobilise the service to respond to pressures from the Covid-19 pandemic and remobilise the service after the stepping down of some activities. Guidance for each plan commission was developed by Scottish Government colleagues in response to what were understood to be the key pressures for the system at the time. Guidance was collated by the Operational Planning Team with contributions from policy teams across DG HSC.

501. Once commissioned, the plans were developed by the Boards and submitted to Scottish Government for review. The responsibility for the development of the guidance lay with Operational Planning team and key policy colleagues across Health and Social Care. Responsibility for the development and implementation of the plans lay with the Territorial Health boards. Territorial Health boards were responsible for reporting on their progress against the plans. Within Scottish Government assessment of this reporting sat with policy teams across Health and Social Care, and collation and summary of these assessments lay with Operational Planning. One of the ways in which progress was monitored was through a regular Chief Executives meeting/teleconference, chaired by the Interim Chief Executive and attended by each of the 22 health boards across Scotland.

502. HSCMB received regular reports from the Interim Chief Executive of NHS Scotland on the progress towards the remobilisation of the health and care system.

503. The NHS Recovery Plan published on 25 August 2021 was led by Tracy Slater, the Interim Deputy Director, Health Performance and Delivery Division, and was developed through engagement with policy, service and Ministerial stakeholders over spring and summer 2021. The Recovery Plan set out key headline ambitions and actions to be developed and delivered over the subsequent five years to 2026, in order to address the backlog in care and meet ongoing healthcare needs for people across Scotland, such as increasing NHS capacity by at least 10% in order to address the backlog in care, recruitment of staff for National Treatment Centres and increase wider primary care capacity to meet ongoing healthcare needs for people across the country.

504. As well as outlining the principles our NHS recovery is shaped by, it also set out the over £1 billion of targeted investment need to deliver improvements in the short term, throughout this five-year term of the Scottish Parliament, and sustainably for the future. The Scottish Government committed to publishing annual progress updates against the NHS Recovery Plan and the first annual progress update was published on 4 October 2022.

505. In the NHS Recovery plan, we committed to publishing a National Workforce Strategy. The National Workforce Strategy for Health and Social Care in Scotland was published on 11 March 2022 in partnership with CoSLA. The Strategy outlines our shared vision for the workforce: 'a sustainable, skilled workforce with attractive career choices where all are respected and valued for the work they do'. This vision supports

our tripartite ambition of Recovery, Growth and Transformation of our Workforce and the actions we will take to achieve this. The tripartite aim supports our NHS Recovery Plan and recovery of our Social Care services and workforce. The Strategy looks at the whole workforce journey, setting a strategic framework for the workforce lifecycle, how we plan, attract, train, employ and nurture our Health and Social Care Workforce. The Strategy acknowledges the challenges the pandemic has brought, not only for our services, but also for our workforce. It acknowledges long term workforce supply challenges, some of which are linked to the declining working age population of Scotland, and expressly commits to increasing our understanding of demographic change in demand for services not least in the aftermath of the pandemic. Through the Workforce Strategy we seek to embed a new long-term approach to our health and social care workforce. In developing the strategy, we worked in partnership with CoSLA and extensively engaged with stakeholders from across Health and Social Care, this included NHS Board HRD's, partners in Social Care through established partnership structures. In delivering and implementing our workforce strategy a National Workforce Forum has been set up, this includes representation from across the Health and Social Care sector and Scottish Government. This forum provides strategic direction, advice, and assurance across workforce interests. It provides challenge and oversight to the delivery of the actions outlined in the National Workforce Strategy to ensure benefits are realised from planned outcomes.

Lessons Learned

506. DG HSC undertook an initial lesson learned exercise about pandemic response from March to September 2020, which was published on 6 August 2021, (CL3/0140 - INQ000147474). In addition, the Standing Committee on Pandemic Preparedness was established by the First Minister and met for first time in August 2021. The Committee published its initial report on 30 August 2022. This report makes recommendations based on insight from the overall response to the pandemic including areas of responsibility for DG HSC.

Preparing for new Covid-19 variants

507. Scotland's primary plan for responding to a pandemic event not related to Covid-19 remains the *UK Influenza Pandemic Preparedness Strategy 2011*.

508. Scotland's preparedness and resilience to new variants of Covid-19 is set out as follows.

509. Since on or around June 2022, the Future Threats and Surveillance Division lead on the governance arrangements for monitoring and responding to Covid-19. They do this with support from:

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

510. '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.

511. The Covid Four Harms Group brings together the views from across the four harms in relation to Covid-19. This includes the views of the CMO (either direct or via clinical colleagues) on the overall threat level of Covid-19 in Scotland and 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 and will form the Programme Board to review plans, risks and issues and activity updates. It meets regularly and so ensures that the Sottish Government remains able to react to an outbreak, variant or mutation.

512. The process map serves 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. Doing this preparatory work enables us to step up our Covid-19 response at pace.

513. The desk instructions have been filled out by the key departments that stepped up a Covid-19 response. As staff move roles, and the Covid-19 dedicated teams reduce in size, the desk instructions ensure that if needed, key files and documents are easily accessible. Teams should regularly update instructions

514. Lessons learned exercises have been, and continue to be, carried out within the Directorate for Population Health. For example, there was a detailed lessons learned report on certification. This activity is also captured for our NPI technical guide which has been designed to inform and support future decision making.

Covid Highest Risk/Shielding Division

515. In May 2020, the Shielding/Covid Highest Risk Division carried out user research to:
- Understand people's experiences of shielding
- Consider what support people might need in the short and long term
- Gather feedback on current services.

516. This is produced: (CL3/0131 - INQ000147411).

517. PHS also published a report in January 2021, showing results from a survey conducted between December 2020 and January 2021, which explored areas such as: the impact of services and support provided by the Scottish Government's Shielding/Highest Risk Division, thoughts on vaccination, and how pausing shielding in Scotland has impacted different aspects of life. This is produced, (CL3/0132 - INQ000147410).

518. In April 2021 there were deliberations on the provision of facemasks and which grade was most effective to be offered to those considered at highest risk of Covid-19. However, the final decision was based on the minimal benefit to offer high grade facemasks to the highest risk group as a whole.

519. In September 2020 Covid Highest Risk Division, with agreement from CMO and Ministers, took the decision to offer a free three-month supply of Vitamin D to everyone on the Highest Risk List. It was decided that the provision of vitamin D supplements was of particular importance in Scotland as there were high levels of deficiency (around 54% in winter, and 17% in summer). Compared to the general population, the shielded population were less likely to get enough sunlight to make vitamin D when they were being asked to shield and stay indoors. Further information is produced, (CL3/0133 - INQ000147409).

520. As additional support we published *'Balancing the risks of everyday living during coronavirus*' on 14 December 2022, to help people at highest risk start to make their

own risk-based decisions. This was based on feedback we had from research that some people on the Shielding List had felt abandoned when shielding paused in August 2020, and a significant proportion continued to self-shield, so this was an intervention designed to encourage people to regain a better quality of life.

521. The Shielding Division had a User Research team embedded in the division and therefore there was a high level of engagement with our service users throughout the period April 2020-April 2022. The purpose of this team was to inform policy design and support packages and embed a deeper understanding of lived experiences of shielding in the division. For example, research was undertaken with service users to inform design and delivery of the Shielding text alert service and of a personal risk information booklet. User research and feedback also highlighted the detrimental affect Shielding had on mental health and wellbeing and contributed to the end of the strict shielding policy (self-isolation). It also identified an appetite for a voluntary social distancing programme which resulted in the development and launch of the Distance Aware scheme.

522. Four separate lessons' learned reports were developed in the Covid Highest Risk Division. These were based on 4 different workstreams; start-up of the Shielding programme (later renamed Covid Highest Risk), Risk stratification work stream, Clinical Policy work stream, and lastly Regional Resilience Partnerships. All reports were developed by members of the Covid Highest Risk division and based on anonymous feedback from surveys sent to former and current colleagues, and former and current stakeholders that had been involved in that particular work stream.

523. Based on Shielding/CHR lessons learned reports, key issues that applied across the division were:

- Having the right numbers of staff but also the people with the right skills in the right places (there was no 'bank' of crisis response-trained people to call upon)
- IT access issues in the early stages, including tools to work effectively from home
- Lack of governance structures for some pieces of work
- Lack of clarity on who were the key decision-makers and in general on peoples' roles and responsibilities (in the early days)
- Reliance on bringing in a large volume of external staff which presented some issues in terms of lack of familiarity with SG/civil service systems and processes.

Test, Trace and Isolate

524. In June 2022, the UK and Devolved Administrations Board, 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 learnt activity.

525. This specific report was not intended to be a clinical review or provide evidence of the absolute impact on transmission of delivery models across TTI but 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.

526. 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, and
- An assessment of aspects of TTI as part of winter preparedness/contingency and how its deployment might support resilience of key workforce groups.

527. In order to deliver this report, officials from Scotland, North Ireland, Wales, and England attended a weekly work group session between June and September 2022.

528. Analytical input including the literature review activity and modelling was delivered by the Health and Social Care Analysis (HSCA) team within the Scottish Government, who have led Covid-19 Test and Protect analysis throughout the pandemic.

529. This 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 UKDA Board following the reconstitution of that board and revised governance from November 2022. The substantive work on this reached conclusion towards end 2022 so has not yet impacted on decisions relating to TTIs.

The Standing Committee on Pandemic Preparedness

530. The Standing Committee on Pandemic Preparedness was commissioned by the First Minister of Scotland to provide advice on preparedness for Future Pandemics, and first met in August 2021. The terms of reference, meeting papers, minutes and interim report are all published and available on the Scottish Government website and will be processed and made available to the Inquiry.

531. This will involve considering the best means of optimising and embedding the protective measures we have become familiar with over the past two years and considering further adaptations that can be made to our buildings, homes, and the built environment/spaces around them. This benefits social and individual wellbeing, wider public health, and Scotland's economy. The SLWG reported to the Scottish Government at the end of March 2022 and made ten recommendations including reviewing building standards and retrofit strategies to embed improvements in ventilation; increasing technical skills in the relevant industries; improving air quality in buildings and raising awareness of the importance of ventilation through a targeted communications approach. A list of the SLWG's recommendations and further details on how the Scottish Government intends to take them forward is produced above in paragraph.

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: 23/06/2023