Witness Name: Caroline Lamb
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UK COVID-19 INQUIRY
MODULE 2 and 2A

STATEMENT BY THE DIRECTOR GENERAL FOR HEALTH AND SOCIAL CARE

In relation to the issues raised by the Rule 9 notice dated 13 December 2022 served on the Scottish Government, in connection with Module 2A, the Director General for Health and Social Care will say as follows:

Introduction

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

2. This statement combines contributions from the Chief Medical Officer (CMO) for Scotland, the Chief Scientist (Health) (CSH) and the National Clinical Director (NCD) for Scotland. Further information on statistical analysis and data science, as well as formulating and communicating expert advice can be provided if required. As a matter of course, those involved in policy development for the Scottish Government are required to consider the impact of this on the Scottish population including those with one or more protected characteristics. This is routinely carried out through the completion of an Equality Impact Assessment and is covered in the Module 2A Director General Communities corporate statement provided on 23 June. In addition to those named in the Rule 9 request, Professor Jason Leitch, CBE, is the NCD for Scotland and works alongside the CMO and the Chief Nursing Officer (CNO).

The Role of the CMO

3. It is understood the date range of the Rule 9 request covers the period from 21 January 2020 (which is the date on which the World Health Organisation (WHO) published its *Novel Coronavirus (2019-nCoV) Situation Report -1* and 30 April 2022 which is the date when the then remaining Covid-19 restrictions were lifted in Scotland. Between 21 January 2020 and 6 April 2020, Professor Sir Gregor Smith was Deputy Chief Medical Officer (DCMO).

4. The current CMO is Professor Sir Gregor Smith. He is a GP and former medical director for primary care in NHS Lanarkshire and began working for the Scottish Government as a medical adviser in primary care in 2012. As medical adviser, he was part of the negotiating team for the Scottish GP contract, subsequently leading the development of a new quality framework for general practice in Scotland. Professor Sir Gregor Smith was appointed DCMO in 2015, interim CMO on 6 April 2020, and was formally appointed CMO in December 2020. He is an Honorary Professor of the University of Glasgow.

5. Previous CMOs have been Catherine Calderwood (February 2015 to April 2020), Aileen Keel as Acting CMO (April 2014 to February 2015) and Sir Harry Burns (September 2005 to April 2014). Aileen Keel also served time as DCMO for the Scottish Government prior to her appointment as CMO, whilst Catherine Calderwood served time as a Senior Medical Officer.

6. The CMO is the most senior adviser to the Scottish Government on health matters. As a senior civil servant with statutory responsibilities, the CMO reports to and is a director within the Health and Social Care directorates and also sits on the Health and Social Care Management Board. The CMO has a more independent status in government than most civil servants. The key responsibilities of CMO are as follows:

    - providing policy advice to Scottish Ministers on healthcare and public health
    - leading medical and public health professionals to improve the mental and physical wellbeing of people in Scotland
    - providing clinical advice on professional standards and guidelines
    - investing in research, particularly related to the NHS
    - encouraging young people to take up jobs in the medical and public health sector

- playing a key role in working with Directorate for Health and Social Care (DHSC) public health agencies and the NHS to convert scientific advice from expert committees into a policy response.

7. Further detail on the role of CMO as well as the wider Scottish Government is provided in the document "Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS led Incident Management Teams" [CL4/0001 – INQ000102996].

Overview of Chief Medical Officer Directorate (CMOD)

8. The CMOD seeks to achieve the best health and care outcomes for people by working with Ministers and stakeholders to protect and improve public health, and to oversee the effectiveness of healthcare services in Scotland.

9. The CMOD is part of the Health and Social Care family of Directorates which is headed up by Caroline Lamb, who was appointed Chief Executive NHS and Director General (DG) for Health and Social Care in January 2021.

10. The Chief Executive of NHS Scotland provides strategic direction to the NHS in Scotland and drives performance, efficiency, value for money and the delivery of sustainable safe, effective and person-centered services – currently with a particular focus on the operational response to the Covid-19 emergency. The DG Health and Social Care is responsible for maintaining a high standard of care for the people of Scotland and for providing support to Scotland's health and social care professionals. The DG Health and Social Care is a member of the Scottish Government's Corporate Governance Board.

Overview of the Chief Scientist Office (CSO) and the CSH

11. As outlined in the Module 1 DG Health and Social Care (CMOD/CSO) statement provided to the Inquiry on 17 February 2023, the CSH remit comprises health research, development and innovation within the NHS in Scotland. The role of CSH is recruited for a period of three years and tends to be held by a senior clinical scientist. The present CSH is Professor Dame Anna Dominiczak, who was appointed in June 2022 and therefore was not in post for any of the specified time period in question. The information provided within this statement in relation to the role of the CSH during the specified time period has therefore been collated using CSO records.

12. Between 21 January 2020 and 30 April 2022, the CSH was Professor David Crossman, an experienced health scientist and Dean of Medicine at St Andrew's University. He was appointed through an open and external recruitment campaign. His term was extended through this period with the agreement of the Civil Service Commission.

13. The CSO is part of the CMOD in the Scottish Government, reporting to the CMO. The CSO was established in 1973 and has had a Chief Scientist since its inception. The aim of the CSO is to identify, promote and encourage research which addresses the health and healthcare needs of the people of Scotland. The CSO seeks to catalyse the research strengths in Scotland and funds research which is of direct relevance to the strategic priorities of the NHS. The CSO research budget supports research infrastructure in the NHS and a range of grant and programme awards.

14. Between 30 September 2010 and 1 March 2012, the Chief Scientist post was reviewed. This review concluded that the post should remain to provide a lead in championing science as a key driver of the economy and provide advice on government policy and its direct investment in scientific activity in our universities and other institutions.

15. The CSH is part of the network of specialist Chief Scientists and Scientific Advisers within the Scottish Government led by the Chief Scientific Adviser and is an ex-officio member of the Scottish Science Advisory Council.

16. The CSO's main tasks are to: (i) ensure that the NHS in Scotland is research and innovation ready by funding NHS Boards to maintain their research infrastructure and provide appropriate national infrastructure; and (ii) ensure access to funding opportunities for researchers in Scotland to conduct health research. In particular, the CSO runs two research committees which, through independent award committees, funds translational research across all health specialties.

17. The CSO also contributes financially to the National Institute of Health and Care Research (NIHR) in order that some of NIHR's research programmes are open to applications from researchers in Scotland. These programmes (Efficacy and Mechanism Evaluation, Health Technology Assessment, Health Services & Delivery, and Public Health Research) also provide opportunities for research related to infectious diseases including pandemic-related research.

Internal restructuring of the CMOD in response to Covid-19

18. The change in CMO between January 2020 and April 2020 did not affect the ability of the CMOD to respond to the pandemic. Being in the role of DCMO prior to the start of the pandemic and in the first few months of it gave Professor Sir Gregor Smith insight and allowed him a smooth transition when he was appointed interim CMO in April 2020. Although the role was on an interim basis between April and December 2020, in practical terms the CMO role was the same and there were no implications of the role initially being interim in terms of ability to respond to the pandemic.

19. Shortly after Professor Sir Gregor Smith took office as interim CMO in April 2020, he reassessed the capacity of clinical advice available to the Scottish Government and identified that having more senior advisers would be beneficial. At the start of April 2020, there was one DCMO and over the Summer of 2020, the number of DCMOs increased to three under Professor Sir Gregor Smith. Each of the DCMOs who were appointed at that time had a broad portfolio and complemented one another's skills and experience. Meetings between the DCMOs and the CMO were held virtually. The three DCMOs who were in post by Summer 2020 were Professor Nicola Steedman, Dr Marion Bain and lastly Dr David Caesar. Professor Steedman and Dr Bain are still in post as DCMOs.

20. During the time Professor Sir Gregor Smith's predecessor, Dr Catherine Calderwood was in post, two 'silver commanders' were appointed. They were two senior clinicians with operational experience who were seconded from the NHS. Their main role was to strengthen the links between development and operation of policy. Following the resignation of Dr Calderwood, she was no longer part of the team and gave no further advice.

21. An internal CMOD advisory group of senior clinical advisers was also created. This group met very regularly and sometimes every morning at the height of the pandemic. The group met virtually and not in person. Its purpose was to create situational awareness and contribute to solving issues and problems. There was also a 'clinical cell' of government advisers and NHS clinicians who met regularly to discuss clinical approaches, evidence, guidance and issues. A professional multidisciplinary advisory group was also set up comprised of doctors, nurses and other professions linked to Scottish Government. These groups were useful advisory fora in which to discuss thorny medical or nursing issues thrown up by the pandemic and seek to reach a consensus on

how best to approach them. These internal response groups provided effective support to the CMO, DCMOs and the CMOD and other senior clinicians in government.

Structures and processes utilised or developed for the provision of advice by the CMOD and CMO to the Scottish Government

22. The structures in place (as discussed below) facilitated the provision of advice to Ministers and their appropriate consideration of it. As discussed in the Module 1 DG Health and Social Care (CMOD/CSO) statement provided to the Inquiry on 17 February 2023, the Scientific Advisory Group for Emergencies (SAGE) was a useful source of evidence and scientific consensus from which the CMO could develop advice for the Scottish Government but the drawback was that the Scottish Ministers could not ask questions directly of SAGE. That was why the First Minister arranged for Dr Calderwood, then CMO, to set up the Scottish Covid-19 Advisory Group (C19AG). Two members of this group were behavioural scientists which was of assistance in how to communicate public health messaging most effectively. C19AG is discussed in more detail in the Module 1 DG Health and Social Care (CMOD/CSO) statement provided to the Inquiry on 17 February 2023 and the Module 2A C19AG statement, provided to the Inquiry on 23 June 2023.

23. During the pandemic, the National Incident Management Team (NIMT) was an important vehicle for gathering evidence from health protection teams around the country. It included representatives from each territorial health board's area. There is guidance available from Public Health Scotland in relation to when the NIMT should be set up within the report produced in paragraph 7. Jim McMenamin, an experienced epidemiologist, chairs the NIMT. There was also the Scottish Academy, an umbrella organisation for the medical royal colleges which assisted in bringing to bear all available evidence, increasing situational awareness of the impacts of the virus, approaches to treatment and issues arising from the clinical community.

24. The CMO had regular contact with the Covid-19 Corporate Analytical Hub. The CMO was involved in discussing the data and gave advice in relation to the presentation of the data. More detail about the role and functions of this Hub is provided in the Module 2A DG Health and Social Care corporate statement, provided to the Inquiry on 23 June 2023.

25. To begin with, cross government co-operation within the Scottish Government was informal. Then the "Four Harms Group" was set up, in Autumn 2020. This was a formal group to consider each of the four harms that had been identified as having been caused or likely to be caused as a result of the pandemic. Those harms were: (i) the direct effect on society's health by the virus (ii) the indirect effect on health as a result of the virus (iii) social (including issues such as loneliness and education) and (iv) economic. The CMO sat on the Four Harms Group. This group also, as part of its deliberation, considered the impact of the pandemic on vulnerable and 'at risk' groups. This group considered the four harms in a rounded way and, as CMO, Professor Sir Gregor Smith recognised that whilst his role was most concerned with harms (i) and (ii), those taking the decisions in government required to consider and balance all the identified harms. The structures and processes in place during the course of the response to the pandemic were generally effective and appropriately set up for the state of knowledge of this novel virus at that time. More information on the four harms and the Four Harms Group is provided within the Module 2A DG Strategy and External Affairs corporate statement, provided to the Inquiry on 23 June 2023.

26. There was also the Four Nations Covid Recovery Group which was chaired by the Chancellor of Duchy of Lancaster and which the CMO would generally attend with a Scottish Minister. In his absence, a DCMO would attend.

27. There was effective collaborative working between CMO, DCMOs, CSO, Chief Scientific Advisor for Scotland (CSA), CSH and NCD and their counterparts across the UK. The role of the CSA is covered in full in the Module 2A corporate statement provided by DG Economy on 23 June. The 'Senior Clinical Advisers Group' was important and instrumental in responding to the pandemic. The Senior Clinical Advisers Group was made up of public health officials, academics, the NCD for Scotland as well as the CMO, DCMOs, and their counterparts in the other UK nations. Evidence was considered and discussed, and efforts to reach a clinical or scientific consensus were made constructively. Constructive discussions took place on how best to respond to the pandemic as more and more was being learned about the virus and on how to frame advice to those responsible for decision-making in government. The effectiveness of these cross UK structures cannot be over-stated. The CMOs of the UK would hold regular virtual meetings. At the height of the pandemic, meetings could take place three times a week or even more. Evidence was considered and debated and the meetings were not simply 'echo chambers'. They were characterised by useful, constructive professional challenge throughout.

28. Meetings of this extended team within CMOD took place remotely almost on a daily basis via Zoom or Teams but generally Teams was the platform used. The CMO and CMOD did not have frequent contact with the CSA Scotland. Most of the contact with the science and research community was either direct or through CSH.

Activity of the CSH between 21 January 2020 to 30 April 2022

29. The emergence of Covid-19 in Scotland necessitated the pausing of many clinical research studies supported by NHS Research Scotland (NRS) to prioritise research on Covid-19 (as well as to reduce infection risks to patients and staff, and to allow clinical research staff to be redeployed to support the NHS front-line). The NRS clinical research infrastructure supported a wide range of Covid-19 research including studies to:

- understand the nature of the Covid-19
- characterise and identify risk factors for Covid-19 illness
- track, characterise, and assess the potential impact of emerging Covid-19 variants
- trial treatments and the safety and efficacy of Covid-19 vaccines.

30. Examples of studies supported can be found on the NRS website. Over the course of the pandemic, data from NRS indicates that Scottish health boards supported 197 Covid-19 studies that involved recruitment of over 53,000 people (as at mid November 2022). CSO provided additional funding through NRS to support Scottish health boards to participate in this Covid-19 research.

31. The CSO worked with NIHR and equivalents in Wales and Northern Ireland on the UK prioritisation process for Urgent Public Health Covid-19 Studies. The UK NHS Covid-19 Vaccine Research Registry that was commissioned by the Vaccines Taskforce and established by NHS Digital and NIHR was in collaboration with CSO and NRS and equivalents in Wales and Northern Ireland.

32. CSO also issued two calls for research: a call for Rapid Research in Covid-19 issued in March 2020 and a call for applied research on the longer-term effects of Covid-19 infection in October 2020.

33. During this period, the CSO oversaw The Adults with Incapacity (Ethics Committee) (Scotland) (Coronavirus) Amendment Regulations 2020 SSI 2020/151 which were made

in exercise of powers conferred by section 51(6) of the Adults with Incapacity (Scotland) Act 2000. These amendments concerned the operation and resilience of the Scotland A Research Ethics Committee (SAREC) dealing with, amongst others, Adults with Incapacity research ethics reviews.

34. Beyond the core role, CSH provided advice and expertise during the relevant time period, into: (i) the C19AG; and (ii) developing testing.

International co-operation

35. The CMO had some informal contact with World Health Organization (WHO), though in the main this contact was co-ordinated through CMO England. There were also regular evidence meetings with Centres for Disease Control and Prevention (CDC) in the USA and the Israeli Health Ministry. These regular virtual meetings took place particularly in the post vaccination phase where evidence regarding the effectiveness of the vaccine was shared, amongst other things, such as latest intelligence on variants and viral properties. There was direct contact between the CMO and colleagues in Denmark in connection with the concern around the virus within the mink population and also indirect contact via UK CMO's group with South African clinicians. Such international co-operation was a very helpful part of the response to the pandemic.

Formulating and communicating expert advice to Scottish Government decision-makers in the Covid-19 pandemic

36. Expert medical and scientific advice was sought, carefully considered and acted upon by Scottish Ministers. The CMO attended Cabinet every week and gave an update of the epidemiology of the pandemic. The CMO sought to explain and 'translate' clinical and scientific advice to enable Ministers to understand it and make their decisions.

37. Prior to presenting complex expert, medical and scientific evidence, data and statistical modelling, the CMO would first look to understand the degree of confidence in that information so that he may advise Ministers accordingly. There were occasions, particularly in the early stages of the pandemic, where data and / or confident evidence was not available given that this was a novel virus. However, where data was available, it was reliably shared freely across the UK. This included epidemiology and research data. There were no instances where requests for access to data, information or expertise were declined, withheld or unavoidably delayed.

38. The public thought that statistical modelling meant projection. In reality, modelling just gave a range of outcomes for a given set of parameters. Modelling was useful, for example, in looking at ranges in the context of the severity of the disease and how infectious it was. However, those ranges were not forecasts and it was important to use modelling in conjunction with other available information. The data on modelling would be presented to senior clinical advisers by analysts. The quality of the modelling was not in question. Modelling, however, is only as useful as the information used to create it and the parameters used to construct it. There is necessarily some ambiguity in modelling, but it is useful to use with other tools. Regular dialogue and contact with the WHO by the UK CMOs and contact with the CDC in the USA assisted in the systematic approach to understanding the nature and spread of Covid-19 outwith the UK. The CMO's understanding of the transmissibility, infection, mutation, reinfection, the nature of the virus including its severity and the measures available to limit it spread and how this understanding developed over the course of the pandemic can be found in the technical report of the four UK CMOs, provided: [CL4/0002 – INQ000130955]. Expert opinions were forthcoming from a variety of sources not only from members of scientific groups. The CMO would read articles and evidence pieces and often approached the authors of such literature directly.

39. Prior to meetings with Scottish Ministers and senior civil servants, policy papers were drawn up and the CMO and CMOD would have input into those policy papers to confirm if interpretation of the evidence/data was correct and whether the CMO agreed, on a clinical basis, with the suggested approach in the papers. The submission would outline an approach with options for Ministers. Scottish Ministers could ask the CMO for his views on which option, in their view, might be most appropriate. The agenda for the meeting would be set by the Ministers.

40. At Cabinet meetings, the First Minister would open the meeting and then the CMO would give an update on the epidemiology and the latest data. The meetings then tended to focus on discussion of the content of policy papers and accompanying scientific evidence. Prior to the meeting, the CMO would have discussions with senior clinicians so that a clinical consensus could be presented to Ministers to enable them to make decisions. There were sometimes wide-ranging views across the wider clinical and scientific community. The CMO sought to formulate his advice on the centre ground where there was most confidence and agreement. It would not have been helpful or useful to present a wide range of different, often conflicting, medical or scientific views to Ministers: the CMO role was to communicate the advice as clearly as possible to enable

Ministers to take decisions. As more was learned about the virus, views within the scientific community could and did change: it was a dynamic process. The key to an effective scientific process is the ability to look at all the available evidence and form a consensus within the appropriate advisory structure, e.g., C19AG, SAGE, NIMT.

41. There were specially convened meetings on particular pre-identified topics, known as 'deep dives', where experts in that area presented evidence. These deep dives gave the Scottish Ministers, and the CMO, the opportunity to ask questions of a scientific or medical expert directly. Many deep dives were convened, particularly at the beginning of the pandemic when evidence was emerging on various issues including testing and vaccines. They were important as they allowed Ministers, notably the First Minister and Deputy First Minister to ask questions of experts directly. These were Scottish deep dives, cross border or UK wide deep dives were not held.

42. Key briefings and information – the passing of knowledge on health matters to the Scottish Government during Covid-19 was not communicated by the CMO to the Scottish Government via WhatsApp or text message communications. There may have been some limited email communication, but key advice would be given by way of submissions provided by policy areas, sent via email. Any emails would have been sent using a work device not on private or personal devices.

43. Key decisions made by the Scottish Government were normally made by Cabinet or delegated for the First Minister to make out of Cabinet. The only decisions made by CMO and CMOD related to clinical guidance provided to clinicians within Scotland.

Initial strategic response to 'super spreader' events in Scotland

44. The advice given to the Scottish Ministers by the CMOD and CMO regarding decisions relating to large scale events, was based on the evidence which came from SAGE. This advice highlighted the increased risk of transmission whenever large groups were in close proximity to each other, especially in indoor environments or areas with poor ventilation. Prior to lockdown (probably around mid-March 2020) Scottish Ministers had formed the view large scale events should be curtailed. Further information on the initial Scottish Government response to 'super spreader' events is detailed within the Module 2A DG Health and Social Care corporate statement, provided to the Inquiry on 23 June 2023.

Decisions about Non-Pharmaceutical Interventions (NPIs) and identification of 'at risk' groups

45. From a medical perspective, groups who may be more at risk from the virus than the general population were identified at an early stage and advice was given to them to shield. The shielding policy evolved over time. There was a particular policy unit in the Health and Social Care DG (DGH&SC), that had responsibility for 'at risk' groups. At the start of the pandemic, some data and evidence was not available. For example, it was not known at the start of the pandemic that the virus may affect different ethnicities disproportionately. Public Health Scotland carried out research into the impact of the virus on different parts of society producing regular statistical reports that included ethnic information. A more substantial report building on these regular updates was subsequently published in Spring 2022, provided: [CL4/0003 – INQ000147479]. This information, alongside other work undertaken and shared elsewhere in the UK, and its findings were taken into account. The racial gradient in terms of risk has now changed again, with some evidence suggesting that it has begun to flatten out and more understanding is required to understand why this is the case.

46. The scope and remit of the CMO's advice relates to Scotland. The CMO recognised that the necessity of some movement across the land border with England might make communicating the message to the Scottish public more challenging where a different approach to NPIs was being taken in Scotland, than it was in other UK nations. However, advice was based on what was considered best for Scotland having regard to the health status of the Scottish population and its characteristics. It is an older population with a higher rate of multimorbidity and underlying illness, and therefore a greater risk than other parts of the UK. The greater development of multimorbidity in the Scottish population generally occurs at a younger age and this is especially evident in areas that are economically disadvantaged. Where there was a divergence of approach to NPIs in Scotland compared with other UK nations, this was driven by the differences in the Scottish population and other factors. Advice was given solely on what was genuinely considered to be appropriate for Scotland. Where it was possible to achieve consistency with the other UK nations, that was desirable, but it was not always possible. Sometimes other UK countries would make announcements at short notice which could impact on public health messaging in Scotland. Overall, there was excellent communication between the UK countries through clinical professional channels where sufficient notice of these decisions was proffered before they became public knowledge. What was more challenging was when the UK Government began to reduce the economic package of

support underlying the NPIs, and this limited the Scottish Government's ability to respond. The Module 2/2A corporate statement provided by DG Strategy and External Affairs on 23 June 2023 covers the topic of divergence in more detail.

47. There was no herd immunity strategy. What was discussed in the early stages of the pandemic and how to respond was the potential compromise on the NHS's ability to cope if high numbers of the population were infected with Covid-19. At meetings of SAGE, the extent to which the NHS would be able to cope and how that would need to be controlled was discussed very early on.

48. For an overview of the advice which the CMO gave the Scottish Government about its strategic response to Covid-19 related to NPIs and what informed that advice, please refer to the technical report produced in paragraph 38.

49. As the evidence increased, and notably when therapeutics and vaccines became available, it was possible for clinical advisers to be much more specific in their advice about the use of NPIs and to move away from the broader approach taken in March 2020. In terms of post-action reviews, the evidence that was being ingathered as the pandemic progressed was dynamically considered and assessed on a rolling basis all the time. In that sense, this dynamic review process informed the advice that was being given with formal reviews carried out by Cabinet. A large part of the advice and opinion given as CMO was highly technical in nature. The four UK CMOs collaborated to write a technical report for future CMOs consolidating key learning from the Covid-19 pandemic, as referenced in paragraph 38.

Public health communications

50. From April 2020, when Professor Sir Gregor Smith was appointed interim CMO, he regularly attended public lunchtime briefings to give clinical and public health advice. His predecessor, Dr Catherine Calderwood, had done likewise. The CNO and NCD also regularly attended and contributed to the lunchtime briefings. This was important to provide clinical transparency to media scrutiny and protective health messaging to the public. In addition, the CMO gave media interviews and was involved in the formulation of public health messaging. The report referred to at paragraph 38 provides further details on the role of the CMO in public health communications. Professor Sir Gregor Smith and his team were regularly involved in discussions with those responsible for

communication and marketing as well as with Scottish Ministers in relation to public health messaging.

The Scottish Government's proposals for public health and coronavirus legislation and regulations

51. Both CMOs in the relevant period provided clinical advice which was sought by policy colleagues. The CMO was also asked to provide clinical input on whether it was necessary to continue with certain coronavirus legislation and regulations as part of the regular review process undertaken by policy teams and the Scottish Government Legal Directorate (SGLD) There are no major ministerial decisions that the CMO disagreed with. As CMO, it was important to recognise that the Scottish Ministers required to balance and consider all four harms including social and economic and that decisions would not be made exclusively on the basis of advice on health matters

NCD for Scotland

52. This request, as well as all historical requests, has not specifically sought information on the role of the NCD for Scotland, a position held by Professor Jason Leitch CBE since its creation in 2015. Professor Leitch is a senior clinical adviser to the Scottish Government alongside the CMO and the CNO. Considering the role of the NCD during the time period requested by the Inquiry, the Scottish Government recognises that the NCD played a significant role in the pandemic response and therefore falls within the scope of this request.

53. It should be noted that the NCD role is unique to Scotland with no direct counterpart in any of the other UK nations. This should be taken into consideration in future requests for information.

54. The NCD is responsible for quality in the health and social care system, including patient safety and person-centred care, NHS planning and implementing quality improvement methods across the government and the broader public sector.

55. The NCD is co-director of the Scottish Government's Directorate for Healthcare Quality and Improvement, providing clinical leadership to the Directorate in partnership with a senior civil servant. The Healthcare Quality and Improvement Directorate is one of the Health and Social Care Directorates in the Scottish Government.

56. In this capacity, the NCD is jointly responsible 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 NCD is jointly responsible for 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.

57. The NCD's directorate helps people in Scotland live longer and healthier lives by:

    - continually improving and providing high quality and efficient public health services that are responsive to people's needs
    - building strong, resilient and supportive communities where people are responsible for their actions and their effects on others
    - helping people maintain their independence as they get older while providing accessible support when needed.

58. The NCD is not a ministerial appointment, and the current incumbent has been in post since the creation of the role in January 2015. The role of the NCD was created in response to the need for a senior clinical leader to prioritise the quality and safety of the health and care system. Professor Leitch works in the Scottish Government on a Service Level Agreement from NHS Scotland (NHS Tayside).

59. The NCD reports to the DG Health and Social Care. While the role of the NCD is not to be wholly independent of the Scottish Government, the NCD is a clinician who will provide independent advice to Scottish Ministers where required.

60. The NCD meets regularly with Scottish Ministers, specifically the Cabinet Secretary for Health and Social Care, through portfolio meetings and other prearranged meetings. These meetings are focussed on the NCD role with policy responsibility in the above-named areas.

61. The NCD provides clinical leadership and engagement with NHS Scotland to drive service improvement through key programmes such as the Scottish Patient Safety Programme, in conjunction with primary stakeholders and Scotland's health boards. The role is also responsible for the delivery of clinical quality and safety across NHS

Scotland, ensuring health boards are prioritising quality and safety of care and encouraging greater mainstreaming of quality and governance at board level. Developing closer collaboration between quality and safety improvement and clinical research, professional regulation and workforce planning is also part of the NCD's role.

62. Professor Leitch has a doctorate from the University of Glasgow, a Masters in Public Health from Harvard T.H. Chan School of Public Health and is a Fellow of the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Edinburgh. From 2005 to 2006, he was a Quality Improvement Fellow at the Institute for Healthcare Improvement, in Boston, sponsored by the Health Foundation. He qualified as a dentist in 1991 and was a Consultant Oral Surgeon in Glasgow. He has worked for the Scottish Government since 2007.

Overview of the NCD role in response to Covid-19

63. It should be noted that the role of the NCD evolved as the emergence of risk became apparent of Covid-19. Early in the response to Covid-19, the NCD became the principal clinical communicator for the Scottish Government, which broadly covered three groups – the public, the Scottish Parliament and Scottish Government stakeholders. The stakeholders were those persons and organisations who were affected by Covid-19, such as hospitality businesses, education establishments, and faith and religion organisations and institutions. It was recognised within the Scottish Government that there was a need not just for political leadership but also for clinical communication, a role which came to be fulfilled by the NCD.

64. While not an official title, the role of the principal clinical communicator was to disseminate, through a variety of communication routes, decisions, information, advice and guidance during the Covid-19 pandemic. The information disseminated by the NCD was not restricted to health-related matters. The NCD also communicated information with regards to school closures and business restrictions, although the underlying reason for this was with regard to Covid-19 public health.

Structures

65. The NCD was supported by several key individuals, most notably those set out in Figure 1.

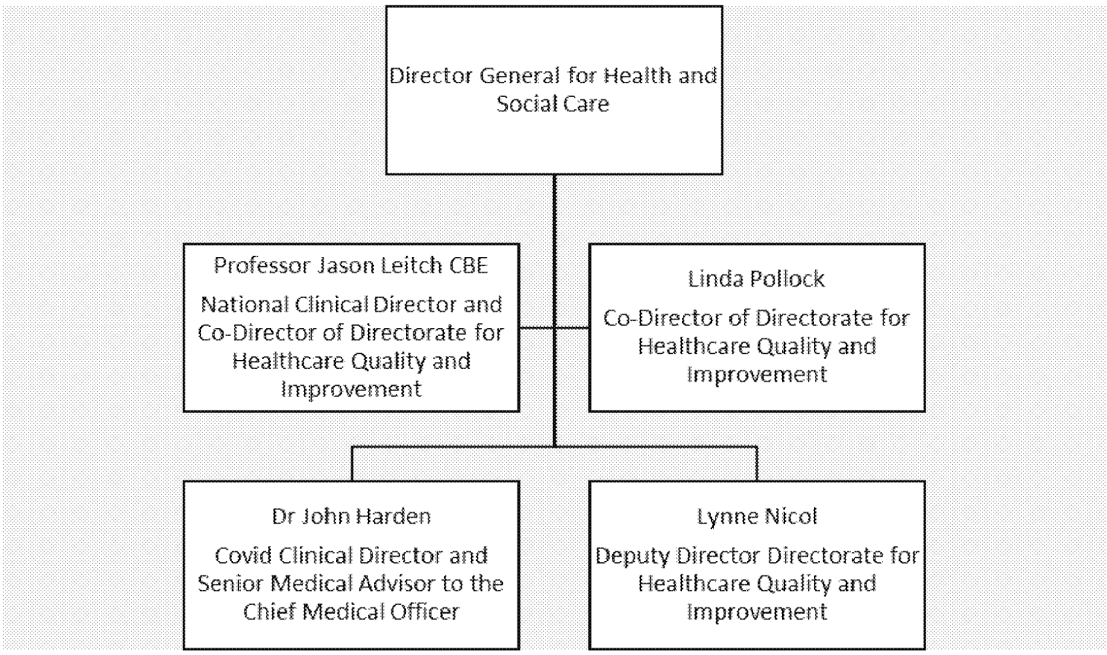

Figure 1: Organogram of support structure for NCD

66. As Senior Civil Servants, both Linda Pollock and Lynne Nicol supported the NCD in matters relating to Government policy.

67. Most significant was the role of Dr John Harden, who was appointed to the Scottish Government in 2016, initially as the National Clinical Lead for Quality and Safety and during the response to Covid-19, as Senior Medical Adviser to the Chief Medical Officer. He was appointed as Deputy National Clinical Director in October 2020.

68. The NCD delegated tasks to Dr Harden and other clinicians to attend to certain aspects of the response. That would include for example attending meetings with stakeholders such as those involved with night clubs or soft play where information or an explanation from a clinician was useful.

Disseminating decisions to the public, Parliament and Stakeholders

69. As the principal clinical communicator for the Scottish Government, the NCD's primary role was to disseminate decisions made by Scottish Ministers to the public, Scottish Parliament and stakeholders. In general terms, this included but was not limited to, public speaking at events, attendance at Scottish Government briefings and writing to key stakeholder groups.

70. In terms of the NCD's role in communicating with the public, the NCD took part in many media briefings alongside the First Minister of Scotland, helping answer clinical questions posed by the media and explaining some of the clinical concepts being discussed in relation to the nature and spread of the virus. The NCD played an important role in national television broadcasts, social media communication and poster adverts to inspire the necessary behaviour changes to help promote public safety and communicating directly with other audiences with targeted messaging to help keep audiences informed about specific concerns. The NCD also wrote to the public on a number of occasions, setting out public health restrictions and guidance, but most notably the NCD wrote to parents, carers and young people in Scotland regarding ongoing public health measures in education establishments to combat Covid-19 outbreaks.

71. In terms of the NCD role in communicating with the Scottish Parliament, the NCD made regular Parliamentary appearances before the Covid-19 Parliamentary Committee. These appearances were at the request of the Convenor. The NCD also supported the Cabinet Secretary for the Constitution, Europe and External Affairs, which was Michael Russell MSP at the time at the above-mentioned committee, on a number of occasions. A timeline of these Committee meetings is provided: [CL4/0004 – INQ000147480]. Other Parliamentary engagement included appearances at various Cross-Party Groups such as the Cross-Party Group for Lung Health. All appearances were at the request of the Convenor of the Group with minutes available on the Scottish Parliament website.

72. In terms of the NCD role in communicating with stakeholders, this was varied in its nature and was dependent on the stakeholder group. However, most significantly the NCD assumed the responsibility of engaging with the business community – especially the hospitality industry – on the gravity of the public health crisis, encouraging direct communication with representatives of affected groups. This included, upon request, appearances at groups such as the Scottish Tourism Alliance.

73. Furthermore, the NCD took a critical role in engaging with Scotland's faith communities and was able to reinforce messaging and engage in supporting spiritual wellness and wellbeing throughout the pandemic. This included public forum meetings with groups such as the Evangelical Alliance.

74. Each week the NCD would receive polling results undertaken on the messaging and whether the public were adhering to the rules. That information would inform the messaging by the Scottish Government. The NCD is not aware of specific evidence that high profile breaches of the regulations affected public confidence in the message.

75. The effectiveness of the communications was monitored by the Communications Division of the Scottish Government, and is covered in further detail in the Module 2/2A statement provided by Director General Corporate on 23 June 2023.

Decision-making in response to Covid-19

76. The NCD did not have a discrete role in decision making in response to Covid-19. Decisions relating to the response to Covid-19 were made by Scottish Ministers. Rather, the NCD was one of a number of advisers who attended meetings and formal groups where advice was formed and submitted to Scottish Ministers.

77. The NCD did not attend SAGE and/or any relevant SAGE sub-groups.

78. The NCD regularly attended meetings of the Scotland Government Resilience Room (SGoRR) during the response to Covid-19. This was to support the NCD role in disseminating decisions and information.

79. While not an official member of the C19AG, the NCD had all the meetings of C19AG in their diary and attended when possible. The NCD contributed to discussions at the C19AG when they attended.

80. The four nation clinical advisory structure which included meetings with the CMO and CSA's, equivalent roles and public health leads from Scotland, England, Northern Ireland and Wales were recognised as crucial meetings during the response to Covid-19. The group was referred to as the UK Senior Clinicians Group. These meetings were carried out via Microsoft Teams, organised by the UK Government and any record relating to the meetings would be held by the organisers. The NCD attended those meetings. These meetings initially took place twice a week and then reverted to once a week. It should be noted that the Medical Director for NHS England also attended these meetings. This group discussed a wide range of matters over time from the deployment of vaccines, the closure of schools and the clinical effect of Covid-19 on children. The group tended to find consensus on the advice to be given to the respective governments. By way of

example of what might be discussed, at the beginning of the pandemic there was no drug treatments available. Research studies were undertaken and showed that patients did better when given steroids. These studies were discussed at the group. This result was then able to be communicated by the NCD to clinicians in intensive care to inform the treatment of patients.

81. Outwith the four nation clinical advisory structure, the NCD, CMO, CSH and the CNO met daily during the response to Covid-19, these meetings were also attended by Scottish Government Directors. Meetings with Scottish Government Health Directors were primarily organised by the DG Health and Social Care's office. Meetings with all Scottish Government Directors and those mentioned above were organised by Strategic Board Secretariat.

82. At various times during the pandemic there were meetings of the four UK health Ministers which the NCD usually attended although did not contribute to the discussion. These meetings happened sometimes once a week although their frequency depended upon the intensity of the pandemic. These meetings discussed common areas of policy.

83. The NCD also attended regular meetings with the First Minister of Scotland, Cabinet Secretary for Health and Social Care (formerly for Health and Sport), CMO, DCMO, Special Advisers, relevant Scottish Government Directors and policy civil servants through a Daily Briefing meeting. It was not the NCD role to brief the First Minister, however the NCD provided advice specifically relating to the communication of key public health decisions where appropriate. However, those meetings were crucial, particularly when the NCD appeared with the First Minister on televised briefings. These meetings were organised by the First Minister's office.

Lessons Learned

84. While the NCD has not taken part in any specific lesson learned exercises, the NCD continues to encourage broader learning from the Covid-19 pandemic. The NCD continues to meet regularly with NHS Scotland and social care staff, speaking to them about their experiences during the pandemic and encouraging them as they deal with the ongoing pressures in health and care.

85. The NCD continues to communicate regularly with national and global audiences about Scotland's journey through the Covid-19 pandemic, including Police Scotland, care

workers, clinicians, business leaders, faith leaders, teachers, parents and carers and school children.

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 June 2023