

CLOSING STATEMENT
on behalf of
PUBLIC HEALTH SCOTLAND (PHS)
in
Module 2A of the UK Covid-19 Inquiry

Introduction

PHS will now be well known to the Inquiry. Since the start of the Inquiry, the organisation has made available a significant amount of contemporaneous material dating from the pandemic and before. It (and a number of senior personnel) prepared lengthy corporate and individual statements setting out in detail information about the workings of the organisation, its role and relationships, and its corporate (and their personal) perspectives and reflections on a range of issues asked about by the Inquiry. Most recently in this Module, the Inquiry heard evidence from three of its senior personnel: Scott Heald, Professor Nick Phin, and Dr Jim McMenamin. It is very much hoped that the Inquiry will now have a good understanding of the organisation, its work, and the views and reflections of it and some its more senior personnel. For that reason, in this closing statement, PHS only intends to make some brief comments on specific issues, focussed in evidence over the past few weeks, where it is felt that it has something to add that may be of assistance. PHS has listened to, and considered the evidence with care, leading to the views expressed in this Closing Statement.

Before turning to its specific comments, PHS wishes to make a number of general introductory remarks.

The continuing impact of Covid

Mr Dawson KC made an important point in his Opening Statement: *“people think Covid is finished; it's not finished for anybody that's touched it.”*¹

To that, we would add that there continues to be new cases of Covid every day. This is on top of the cases of people who contracted Covid previously, but who went on to develop symptoms of long Covid (thought to be in around 2% of all cases). Over and above the suffering caused, as Scotland's national public health body, PHS is concerned about - and

¹ Transcript 16 January 2024, p3 line 14

retains a focus on - the additional pressure these cases place on the NHS in Scotland, specifically arising from the increase in GP presentations and hospitalisations.

Learning lessons

It has often been said, and by many, we need to learn lessons and we need to do so as quickly as possible. PHS agrees. When the next pandemic strikes (as it undoubtedly will) we need to ensure that the right lessons have been learned. In addition, and of equal importance, we need to ensure that those lessons have been given effect.² If these goals are to be achieved, the process of learning lessons from the pandemic cannot be delayed. In Scotland, important work in that regard has begun and continues today. For example, lessons are being learned by comparing and contrasting the Scottish and UK experiences with those of other countries. It is expected that this evidence base will expand as the development work of a proposed Centre of Pandemic Preparedness - led by PHS and on which the Inquiry has already heard evidence - progresses and will be combined with contributions from other initiatives globally.³ PHS has itself learned a considerable amount from listening to the evidence in this module and it looks forward to considering the findings and recommendations of the Chair in her Report in due course.

Putting into practice some of the lessons learned to date

PHS has been considering what the organisation “would do differently next time” and it has put in train changes which it believes are improvements on what was in place at the time of the pandemic. As would be expected, this work has involved the field of health protection, but also the wider impacts of the pandemic including, for example, PHS’s responsibilities in relation to health inequalities. PHS has implemented improvements in surveillance such as the development of our Community Acute Respiratory Infection programme and the programme to monitor Severe Acute Respiratory Infections in hospitals. It is intended that these will help identify a potential new respiratory infection at an early stage and provide insights into its characteristics, transmission dynamics and other important disease parameters. We have been developing our capabilities in managing, linking and using data

² see, e.g. the evidence of Professor Paul Cairney who spoke about “*learning feeding into action*” – Transcript, 18 January 2024, p56 lines 2-4

³ Paragraph 21.3.2 , Witness statement of Dr Jim McMenamin dated 29/11/2023 (INQ000360968)

(for example, in relation to better using health inequalities data or in gauging the effectiveness of the influenza vaccine). It must be recognised, however, that this work is set against a backdrop of limited resources, something that will continue in the foreseeable future. PHS will need to exercise careful judgment in relation to how it employs its resources to achieve the right balance between adequately discharging its day to day public health functions and the more specific responsibilities it has in relation to pandemic preparation and response. In doing so, PHS considers it is important for it to retain a focus on harm in a broad sense, in keeping with the Four Harms approach. It is critical that those who will be impacted most significantly are at the centre of the preparations for the next pandemic.

Learning lessons going forward

PHS is currently leading a multi-agency, National Incident Management Team (NIMT) Lessons Learned Exercise.⁴ Part of the strength of this exercise, PHS believes, is that it is being carried out on a collaborative basis, with input from all of those involved in the NIMT. It is expected that the finding of the review will be available in the summer of 2024.⁵

PHS comments on specific issues

1. ARHAI

Mr Dawson KC asked Professor Phin and Dr McMenamain a number of questions around the merits of the decision to administratively separate ARHAI from the health protection function of PHS⁶. This matter is currently being considered by an independent review (the "ARHAI Location Review")⁷ which will consider the risks and benefits of the current arrangements. The Review's report is expected in April or May 2024.

⁴ Paragraph 68.1(c), Witness statement of Dr Jim McMenamain dated 29/11/2023 (INQ000360968)

⁵ It had been hoped that the findings would be available at the end of 2023 but for various reasons this has not been possible.

⁶ Transcript 19 January 2024, p161-166

⁷ The Review was commissioned by Scotland's Chief Nursing Officer

2. Access to Ministers

Mr Dawson KC asked Professor Phin in evidence whether he thought PHS could or should have been able to provide more direct information and advice to ministers given their central role in the public health response.⁸ PHS considers that this issue revolves around identifying “appropriate” access to decision makers. Whereas Public Health England (now the UK Health Security Agency) attended COBR, provided advice directly to ministers and senior officials, and on occasions stood next to the prime minister or senior minister at media briefings, this was not the case in Scotland. PHS gave advice during the pandemic through NIMT, Scottish Covid Advisory Group or senior advisors within Scottish Government such as the Chief Medical Officer. PHS believes that the current system may strike a reasonable balance. However, given the importance of the subject matter, and given different views have been expressed, this is a matter which merits further discussion with a view to improving the effectiveness of the process, to the extent that this is possible. PHS will engage with Scottish Government to take this matter forward.

3. Care sector

At the outset, PHS wishes to acknowledge the very significant public interest and concern around this subject, in particular following the many deaths of care home residents linked to Covid.

(i) Engagement

The Inquiry heard evidence from Dr Donald Macaskill of Scottish Care who voiced criticisms of Health Protection Scotland (HPS) and PHS. Amongst other things, he expressed the view that there was general lack of engagement with the care sector by HPS and PHS during the pandemic. Dr Macaskill gave powerful testimony. PHS treats all criticisms of the organisation, including Dr Macaskill’s, with the utmost seriousness.

PHS is clear that from March 2020 onward HPS (and then PHS) was working hard to provide input into guidance across a range of settings including the care sector and that the circumstances were challenging. As set out in the evidence, the rapidly developing understanding of the risks associated with transmission caused there to be need for regular

⁸ Transcript 19 January 2024, p175 lines 14-17

updating of guidance. The process had problems associated with it including at times in reaching timely agreement with a variety of stakeholders, including the care sector and government at Scottish and UK levels, around use of language in guidance, all of which meant that the process of keeping guidance up to date proved challenging. There were demanding deadlines regularly imposed on everyone involved including Scottish Care. PHS regrets the impression given that Scottish Care was not being listened to and its input not valued. PHS is clear that this was not the intention, and that the input of Scottish Care was viewed by the organisation as valued and necessary.⁹ It is also perhaps worth observing in this context that there is always likely to be tension to some degree in a process in which, on the one hand, one is trying to ingather as full a range of views as possible from across the sector, but on the other, meet a real and pressing need to get guidance out quickly. Although PHS certainly does not claim to have got everything right on every occasion at that time, based on its understanding of matters, it does sincerely believe that it did its best to balance the considerable competing demands placed on it as well as was possible in the circumstances. The creation of the Policy Alignment Check process from June 2020 onwards ameliorated some of the difficulties described but there remained problems.¹⁰ Looking forward, PHS recognises that improvement will be necessary on a number of fronts. It believes that collaboration is a key aspect of how to make effective improvements. With that in mind, PHS will seek discussions with the Scottish Government, the Convention of Scottish Local Authorities (CoSLA) and the care sector with a view to agreeing what might be done to improve our approach in the future.

(ii) Guidance

In evidence, Mr Dawson KC put a number of criticisms to Professor Phin and Dr McMenamin about care home guidance. The guidance had been published by HPS/PHS on the back of policy input from the Scottish Government. Professor Phin and Dr McMenamin spoke about the facts that: the purpose of the guidance was to provide principles that could be adapted for health and care settings; no guidance can answer every question; and finally, it was local authorities and NHS board colleagues who had (and have) the direct relationship with care

⁹ Paragraphs 50.28 and 50.29, Witness statement of Dr Jim McMenamin dated 29/11/2023 (INQ000360968)

¹⁰ See PHS Module 2A Opening Statement

homes and with whom there was opportunity for dialogue¹¹. Having reflected further on this matter, PHS would add that in its view there can be further consideration given to guidance to ensure there is better "read across", including greater clarity around roles and responsibilities - i.e. where the responsibility of one organisation stops and the responsibility of another organisation starts. This is by no means intended to be a complete answer to the important issues that have been raised by the Inquiry but represent the organisation's further reflections at this time.

(iii) The consensus statement

In PHS's view, an important piece of evidence referred to during the hearings was the "consensus statement"¹² which was commissioned by the Department of Health and Social Care and referred to by Professor Phin in his evidence¹³. For present purposes, PHS notes that the views expressed (that hospital discharge would not appear to have been a prominent feature of transmission in the health care setting, but that risk of transmission through care home staff or visiting professionals was) are significant and will be an important source of evidence in informing the content of care home and other guidance going forward.¹⁴

(iv) Data and care homes

While giving evidence, Scott Heald noted that there were important gaps in data relating to social care and, in particular, care homes. PHS, working with Scottish Government and CoSLA, have established a Social Care Data and Intelligence Programme Board to oversee developments in social care data and ensure progress is made to address gaps and to streamline and make best use of data from the social care sector. This includes data for care homes. This involves a multi-agency review of the care homes data landscape to ensure a coherent suite of data collections, reduce the burden on data providers and meet the existing and emerging needs of data users. This review is expected to report in early 2024/25.

¹¹ Transcript 19 January 2024, p219 to 220

¹² See Report from Scientific Advisory Group for Emergencies titled *Consensus statement on the association between the discharge of patients from hospitals and Covid in care homes, dated 26/05/2022 (INQ000343826)*

¹³ Transcript 19 January 2024, p212 onwards

4. Communication with the public

(i) Incident response - NIKE conference

Dr McMenamain was asked in evidence questions about the sharing of information with the public in relation to the NIKE conference¹⁵. Mr Dawson KC suggested to him that the fact that certain information, available to HPS at the time, had not been published, created, or contributed to, an apprehension that something had been hidden from the public. Whilst stating that there were public health arguments against disclosure, Dr McMenamain acknowledged that, in retrospect, it might have been possible to achieve a "middle ground" by "*anonymising but still releasing information*" assuming the agreement of the Chief Medical Officer¹⁶, and that it was "*very important to keep the public with us in any of our communication.*" PHS has reflected further on this issue and notes that it is an important area that will require further consideration. Without having had an opportunity yet to consult with its partner bodies (including, for example, the Scottish Public Health Protection Network), PHS believes there is room for improvement in how things are done in relation to this area. At this time, it considers it may assist to have in place a protocol with more clearly expressed criteria which require to be taken into account when determining what information should be shared publicly.

(ii) Getting data into the public domain

In his evidence Scott Heald discussed the importance of getting data-related information into the public domain. He accepted Mr Dawson's suggestion as fair "*that efforts were necessary in order to get the information to the people who were most affected and those efforts might have been done better*"¹⁷. Mr Heald said, "*there is always learning with these things. I think that the key thing was that we were doing our utmost best to get the data out to the public in as easy accessible formats as possible on a daily basis and this was running every day with data asked adapting to different stages of the pandemic. So there's always learning from these approaches but I think we did our utmost best to present data in a way that people could*

¹⁵ The decision not to make the incident public was made by the CMO on behalf of Scottish Government.

¹⁶ Transcript 19 January 2024, p226

¹⁷ Transcript 17 January 2024, p103 lines 5-8

*access it and use it and understand it.*¹⁸ During the pandemic, public daily briefings by the Scottish Government was one way by which all headline statistics were made available publicly and subsequently televised and widely reported by the media. However, PHS would wish to add to this that, as part of its obligations under the Code of Practice for Statistics regulated by the Office for Statistics Regulation, it keeps methods for publishing statistics under review. Responding to user feedback is an important part of this. The accessibility of our statistics is crucial – this includes accessibility of our digital products (e.g. to ensure they are accessible to visually impaired users). PHS’s accessibility statement describes the steps PHS is taking to ensure our products are accessible and describes how it makes information available in alternative formats – it wants to continue to engage with key user groups to ensure all its products are accessible for their needs, including those who are unable to readily access via digital means.¹⁹

5. Urgency of initial response

Professor Woolhouse said the following in evidence: *"And so I was getting a sense of what level of activity was going on in Scotland, and I didn't get the impression that it was, in my view, treating the situation with the seriousness or the urgency that I felt it needed."*²⁰ This was after having said that he had been in touch with Chris Robertson at HPS and through him with Dr McMenemy²¹. PHS has reflected on whether it considers there was a lack of seriousness or urgency on the part of HPS/PHS. With respect to the views of Professor Woolhouse, it remains PHS’s opinion (as set out in the PHS individual and corporate statements²² and the oral evidence of Professor Phin and Dr McMenemy)²³ that the organisation reacted as quickly and with as much urgency as possible given the resources available and what was known at the time, including evidence, opinion and advice at international and UK level. Moreover, it viewed what was happening with appropriate seriousness.

¹⁸ Transcript 17 January 2024, p103 lines 9-18

¹⁹ Accessibility statement for Public Health Scotland - Public Health Scotland

²⁰ Transcript 24 January 2024, p11 lines 9-13

²¹ Transcript 24 January 2024, p11 lines 4-7

²² Witness Statement of Public Health Scotland, sections 2.4 and 4.3 (INQ000300280); Witness Statement of Dr Jim McMenemy, section 14 (INQ000360968)

²³ Transcript 19 January 2024, p.187

6. Testing capacity

Professor Sridhar said in evidence: *"It felt like this was the time to push for it and it seemed feasible. And if you read the elimination plan I put together -- which I've submit and went through the advisory group -- it wasn't saying lockdown, it didn't even mention the word "lockdown", what it mentioned was extensive testing, we had a lot of unused testing capacity in Scotland, so I was like: we should be testing much more."*²⁴ With respect to Professor Sridhar's views, PHS believes that the assertion around "unused testing capacity", as understood, is not borne out by the evidence of PHS. PHS addressed in evidence the issues around the significant challenges in the early days of the pandemic given the limited availability of testing.²⁵

7. Testing infrastructure

In his evidence Professor Gregor Smith spoke about the need for a sufficiently agile infrastructure. He said: *"And I think of the – one of the major lessons which certainly I would want to see carried through following this, and I'm very glad it's been captured within the report of the Standing Committee on Pandemic Preparedness, is to make sure that we've got an infrastructure which is sufficiently agile enough, particularly around about testing, and a public health reference laboratory testing infrastructure would for me, be ideal to be able to turn its attention to emerging threats as they were identified in a way which was different from our experience in February and March of 2020....one of the major pieces of learning that I would certainly want to single out from this, is that there are particular parts of the infrastructure which were put in place that, whilst we could never maintain at the levels that existed during the height of the pandemic, certainly need to be there in a way where we could pivot in as agile a was as possible"*²⁶ PHS strongly agrees with these comments. Indeed, PHS would underline the observations make by Professor Phin and Dr McMenemy²⁷ around the need for a sufficiently capable, experienced and flexible public health resource in Scotland, particularly in health protection. In particular, PHS would note the papers provided by

²⁴ Transcript 23 January 2024, p150, lines 5-12

²⁵ Transcript 19 January 2024 p204-205 and the Witness Statement of Public Health Scotland paragraphs 5.2.14 to 5.2.31. (INQ000300280)

²⁶ Transcript 22 January 2024, p131 line 18 to p132 line 14.

²⁷ Witness Statement of Professor Nick Phin, paragraph 11.2.1(i) (INQ000339576); and Witness Statement of Dr Jim McMenemy, paragraph 14.16 (INQ000360968)

Professor Phin in his written evidence to the Inquiry setting out proposals to develop and maintain the public health microbiology function in Scotland²⁸ and a pathogen genomic service for Scotland²⁹.

8. Conclusion

If anything has been said in this document which gives rise to further questions on the part of the Inquiry, PHS would be very happy to assist in any way that it can.

²⁸ Public Health Scotland, *Executive Summary: Gap analysis of Public Health Microbiological services in Scotland: Analysis across One Health Microbiology disciplines to meet Public Health/Health Protection requirements*, dated 30/08/2023. (INQ000319421)

²⁹ Scottish Government, *Genomics in Scotland: Building our future. Our strategic intent to deliver an equitable, person-centred, population-based genomics service and infrastructure for Scotland*, dated 01/03/2023. (INQ000319426)