Witness Name: John Connaghan

Statement No.: 1

Exhibits: JC

Dated: 07 December 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR JOHN CONNAGHAN

In relation to the issues raised by the Rule 9 request dated 08 August 2023 in connection with Module 2A, I, John Connaghan, will say as follows: -

1. I am John Connaghan, Chairman of NHS Lothian, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG and formerly the Chief Operating Officer of NHS Scotland. I have a BA (social sciences and economics) and an MBA from Strathclyde University along with a postgraduate Diploma in management science from Strathclyde University. I am a graduate of the Cabinet Office Top Management Programme. I joined the Scottish Government ("SG") as a secondee in January 2019 after a period working in Dublin as the Director General ("DG") of the Irish Health Service. Prior to Ireland I held posts in SG (2006 onwards) and in NHS Scotland as Chief Operating Officer and Chief Executive of various Hospital Trusts

2. I worked from January 2019 onwards as Chief Performance Officer in the SG Health Directorates. This was a fixed term 2-year appointment to improve the operational performance of the NHS with a particular emphasis on waiting times. I took the job title of Chief Operating Officer in Jan 2020 to reflect the wider role I played in the response to Covid-19. In May 2020 the DG of the NHS resigned due to ill health. I was asked to take up the role of Chief Executive of the NHS on an acting basis with the role of DG taken up by a senior civil servant (previously the posts of CEO/DG were

combined). This role provided advice to Ministers on the pressures facing the NHS – with particular emphasis on intensive care capacity and the number of beds occupied by Covid-19 patients. The role of CEO faced outwards to the NHS and provided advice to NHS Boards on the continuation of critical services.

3. I have prepared this statement myself by reference to records and material provided to me by SG. I have also received assistance from the SG Covid Inquiry Response Directorate.

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

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

Role and responsibilities

6. In my role, I did not personally participate in any UK wide committees, groups, or forums. My directorate was involved in the national UK wide exercise to purchase Ventilators – with Scotland receiving a pro rata allocation. Inside SG I attended the Health and Social Care Management Board ("HSCMB") held on a regular weekly basis and attended any daily Situation Report or "Sitrep" meetings convened by the DG (these Sitrep meetings were held to ensure that the latest information on the progression of the disease and the impact on the NHS was available to all HSCMB members). I also attended the NHS recovery meetings convened by the Cabinet Secretary involving a wide range of stakeholders. My principal role for Ministers was to provide advice on the pressures facing the NHS and to ensure that the NHS implemented Ministerial decisions appropriately in a timely and safe manner. For an example of advice provided to Ministers please see my submission of 24 June 2020 regarding "Acute Sector Waiting Times" to the Cabinet Secretary for Health and Sport, provided [JC/001 – INQ000244013].

7. My role also faced outwards to the NHS and to provide guidance to NHS Boards. Copies of letters issued to NHS Chief Executives dated 11 March 2020, 14 May 2020 and 16 November 2020 are provided [JC/002 – INQ000326477], [JC/003 – INQ000260868] and [JC/004 – INQ000326479]. My role did not extend to offering guidance to Local Authorities.

Initial understanding and response to Covid-19 (January to March 2020)

8. I became aware of growing international concern on a new respiratory virus originating in WUHAN during the end of the first week/early second week in January 2020. One of the key meetings early in the pandemic was the Health and Social Care Management Board (the regular meeting of Health Directors chaired by the DG of Health and Social Care). Between mid-January and very early February SG Health Directorates were already preparing for a national response to Covid-19. An example of this is contained in the minutes of the meeting of 22 January and 29 January 2020, provided [JC/005 – **INQ000273991** [JC/006 – INQ000326481].

9. Given that this was a novel coronavirus, and all national Governments were unsure of the disease progression pathway in the very early stages I consider that the NHS in Scotland acted swiftly as it assessed the impact on other countries Health Services such as Italy, India and China. It built on the established resilience framework that already existed and the pandemic planning guidance that had been in existence for a number of years. While this was geared to flu pandemic preparation the NHS in Scotland was exceptionally agile in reacting operationally to a new virus. From my own personal perspective, we acted very swiftly to increase ICU capacity and to secure "surge Capacity" within the NHS.

10. I have no knowledge nor any recollection of any discussion on the application of herd immunity in Scotland or the UK. Nor was I involved in any discussions on the Nike conference or the 6 nations match. The NHS in Scotland took its own decisions on the NHS Operational responses to the outbreak such as standing down elective capacity and increasing intensive care capacity.

11. My principal role during the early period of Covid-19 was the provision of daily/weekly advice on the impact of Covid-19 on the NHS in Scotland. Attached is an example of the Covid-19 reporting system [JC/007 – INQ000326482] we used which was compiled from various Directorates within SG (my directorate supplied intelligence from Boards on the latest impact of covid as a contribution to this report). This supplemented any clinical or modelling advice which was provided separately to Ministers.

12. My principal advice to Ministers was the need to prioritise creating additional capacity for Covid-19 patients. From March 2020, as outlined above at paragraph 7, the SG instructed NHS Boards to implement several key actions at pace, that enabled them to treat Covid-19 patients while maintaining vital emergency, maternity and urgent care. For instance:

    - All non-urgent surgery, treatment and appointments were suspended, and national screening programmes for some types of cancer were paused. This enabled existing facilities and equipment to be repurposed and staff to be retrained and redeployed to support the response to Covid-19.
    - The number of intensive care beds was increased from 173 to 585.5 (with the potential for further surge to approximately 700 beds). This meant that the NHS had sufficient intensive care capacity throughout the first wave of the pandemic. The number of Covid-19 patients in intensive care beds peaked at 221 on 12 April.
    - NHS workforce capacity was also increased, which enhanced NHS resilience. During the first wave of Covid-19, 4,880 nursing students were deployed, registration dates for 575 junior doctors were brought forward and recently retired NHS staff were invited to return to work. An accelerated recruitment portal was also launched, which received 16,000 expressions of interest.
    - Digital improvements were rolled out across the NHS including software to facilitate working from home, and the use of virtual appointments such as 'Near Me' increased. 6 Video consultations increased from about 300 per week in March 2020 to more than 18,000 per week in November 2020. By December, more than 600,000 video consultations had taken place.
    - The NHS Louisa Jordan, a temporary hospital at the Scottish Event Campus in Glasgow, was established. It was set up in under three weeks and was

operational by 20 April, with an initial capacity of 300 beds, and the ability to expand to 1,036 beds if needed – including 90 intensive care unit (ICU) beds.

- Covid-19 community hubs and assessment centres were established. These hubs assess patients presenting with Covid-19 symptoms in the community, relieving pressure on GP surgeries. Between March 2020 and January 2021, over 250,000 consultations for advice or assessment were conducted through these hubs and centres.

13. What worked exceptionally well was the daily sitrep reporting from Scottish NHS Boards where details of staff vacancies, sickness levels, bed pressures, ambulance performance, provision of critical services etc was provided as a daily update and coordinated through my Directorate. Coordination within and across SG Directorates generally worked well. However, this should be viewed in the very early days of the pandemic against the background of a novel coronavirus where the potential impact on society and the NHS was relatively unknown. Perhaps the biggest operational obstacle was the scarcity of ventilators (worldwide) in the first few months of the pandemic. One operational response worth noting was the repurposing of anaesthetic machinery in theatres which was available for short term ventilation of patients if required.

14. The Audit Scotland report, NHS in Scotland 2020" published Feb 2021 [JC/008 – **INQ000148761**], recognised this in their summary, "The *NHS implemented several actions during the first wave of Covid-19 that prevented it from becoming overwhelmed, such as increasing intensive care capacity and stopping non-urgent planned care."*

Role in relation to non-pharmaceutical interventions ("NPIs")

15. My belief is that one of the principal reasons for the national (UK and Scottish) lockdown was the impact on the NHS and an assessment through modelling that rapidly growing hospital numbers would leave the NHS unable to provide critical services for patients (such as cancer and emergency care - see comments above at paragraph 12 re: response strategy from NHS Scotland).

16. My view at the time in mid-March 2020 is that the decision to impose lockdown was a very quick response - the first death in Scotland had occurred shortly before and the numbers in hospital were low.

17. I have no opinion to provide on the timeliness of second or subsequent lockdowns in either the UK or in Scotland. The NHS by that time was well prepared – we had a range of contingency arrangements in place and our patients in hospitals with Covid-19 never exceeded our available surge capacity.

18. The provision of advice from my Directorate was principally on the NHS impact of Covid-19 as previously stated – I have nothing to add on the provision of face coverings or on national vs local lockdowns nor timing. Nor on any social or economic impact of policies or on disadvantaged or at-risk groups with the exception of those vulnerable patients who are part of our clinical prioritisation approach in making "protected" NHS capacity available (e.g., cancer).

19. I have no opinion to offer on any breaches of the rules by Ministers or officers nor on behavioural management strategies (with the exception of our campaigns on asking people to only attend hospitals when necessary and on reassuring the public that the NHS was open. My role in that was to provide advice to Boards on what should be prioritised in terms of services to be available to the public, such as cancer services (see paragraph 7 above re: guidance to Boards). Both of these messages were effective in achieving our aims to ensure NHS capacity was appropriately accessed by patients). I also cannot comment on any legislation passed as I had no involvement in providing advice on the content or process.

Divergence

20. I have no opinion to offer on Divergence between countries' policies to managing the Covid-19 pandemic. In hindsight it seems sensible to me that each nation must have the ability to quickly respond to operational pressures which impact on particular localities.

Role in relation to medical and scientific expertise, data and modelling

21. The provision of advice to Ministers partially relied on the forecast impact of the disease on bed capacity within the NHS. It was important to realise that this came with upper and lower confidence limits and that the NHS had to prepare for a reasonable worst-case scenario. I used the modelling supplied by our SG analytical colleagues to provide advice on potential capacity issues for ministers and to produce guidance for NHS Boards (as provided at paragraph 7 above). The provision of regular modelling updates from UK sources and SG colleagues greatly assisted our assessment of future risk and helped in planning our response. The development of the modelling to differentiate between Health Boards and the provision of that information to Boards also worked well as it allowed a tailored local response. I have no knowledge of SG being restricted re: information. I am aware from my attendance at Sitrep meetings and from attendance at HSCMB of regular updates from the CMO on his engagement with the other 4 nation CMOs. It should be noted that a national *Coronavirus: Action Plan* was published on 3 March 2020, endorsed by the 4 home nations [JC/009 – INQ000233560]. This covered the current response and next steps.

Role in Covid-19 public health communications

22. What worked well was the public response to attending Emergency Departments from minor injuries and ailments. Local and national messaging to attend hospitals when only strictly necessary saw a significant fall in those attending Accident and Emergency departments. This allowed staff to concentrate on the most serious cases - however, this was also supplemented by the 'THE NHS is OPEN' campaign to encourage attendance where clinically appropriate.

Role in public health and coronavirus legislation and regulations

23. As per the remit and responsibilities of my role, I had no involvement in the development of public health and coronavirus legislation and regulations.

Key challenges and lessons learned

24. I attended a parliamentary committee meeting of the Health and Sport Committee on 17 June 2020. The Official Transcript is provided [JC/010 – INQ000326483]. This was a meeting convened to examine SG's Resilience and Emergency planning with reference to Covid-19. I supported (along with Jason Leitch) the Cabinet Secretary's appearance at this Committee. The main interest of the committee was tounderstand how well the SG was prepared for the pandemic. My contribution to that Committee was to advise on NHS operational response which was provided to the Committee [JC/011 – INQ000326484].

Informal communications and documents

25. I am aware WhatsApp messages (in which I participated) exchanged regularly between Directors of SG. I have no recollection of them playing any part in decision making. When I left SG, I left any paper notes in my office, and I believe these have been securely destroyed in accordance with SG Records Management Policies. All WhatsApp messages were left undeleted on my work phone which was the property of SG and returned at the end of July 2021 when I left office. I have also recently retrieved a personal phone which was no longer in use. This contains text messages to the Cabinet Secretary for Health that relate to Covid, and these will be supplied to the inquiry.

26. Relevant illustrative correspondence to NHS Boards and Submissions to Ministers have been provided with this statement which I have prepared myself without discussion with previous or current colleagues. It reflects to the best of my ability and knowledge a true response to the information requests from the UK Covid-19 inquiry and is supported by material from SG obtained through the Covid Inquiries Response Directorate to which I am indebted.

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: 07/12/ 2023