Witness Name: Gillian Russell
Statement No.: 2
Exhibits: GR2
Dated: 16 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF GILLIAN RUSSELL

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

1. I have worked in the Scottish Government since August 1992. The first 18 years of my career were as a Government lawyer. I then moved into the Senior Civil Service undertaking a range of policy roles before stepping up to the interim Director role for Safer Communities in June 2015. This became a permanent role from January 2016. I joined The Directorate for Health Workforce as the Director of Health Workforce on 16th March 2020. This became a job share arrangement with Sean Neill from April 2020 to March 2021. This was to provide sufficient senior leadership over this period in recognition of the scale of work. From March 2021 I continued as sole Director of Health Workforce and remain in that post now. As a senior official within Government, I was aware of Covid-19 and the emerging response from December 2019. It was clear that the Scottish Government appreciated the seriousness of the pandemic. In the week that I joined, the NHS was put on emergency footing due to the Covid-19 pandemic. This statement refers to the facts and evidence following my appointment as the Directorate for Health Workforce

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

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

4. References to exhibits in this statement are in the form [GR2/number - INQ000000].

Director General Leadership

5. In the early days after joining DG Health and Social Care it was clear that the pace and scale of the response would require significant additional staffing. It was also clear that alternative ways of working required to be put in place rapidly. The senior team supporting the Cabinet Secretary for Health were working 7 days a week. Director General Malcolm Wright put in place military support, which was designed to help strategic command capability and enable effective prioritisation and decision making. The military provided support to the Directorate General over a period of months to enable optimum pandemic response and capability building. This included improving resilience, creating effective challenge to internal thinking and delivery proposals at pace and to scale. When Malcolm Wright left I worked closely with Elinor Mitchell and then Caroline Lamb. For the period between April 2020 and March 2021 I had the support of Sean Neill, who was Interim Director of Health Workforce.

Directorate Leadership

6. As the Director of Health Workforce during the period in question my focus was to:
    - Provide Workforce planning and modelling to support wider decision making on service provision and on the pandemic response
    - Enhance the capacity and capability of the Health Workforce through creating additional resource
    - Support the Health Workforce through wellbeing and related initiatives
    - Adjust the terms and conditions and policies at national level to create a Workforce framework that took appropriate account of wider decision

making on the Non-Pharmaceutical Interventions (NPIs) amongst other things

- Ensure that wider decision making was informed by an understanding of the Workforce
- Support wider decision making across the Directorate
- Lead the Directorate, making sure there were the right skills, in the right place at the right time to develop and implement policies for the Workforce across the pandemic period

7. As Director of Health Workforce, I had responsibility for a range of wider business as usual issues such a negotiating pay, terms and conditions for the Healthcare Workforce, medical education and training, workforce practice, workforce planning, leadership and talent management as well as planning and NHS recovery and miscellaneous issues.

8. I would note that in relation to the pandemic response in the main, my role was to ensure that adjustments were made to the overall policies that were applied to the Health Workforce. This supported decision making in areas like infection control, implementation of NPIs and doing so through effective partnership working with trade unions and employers.

9. During the late spring and summer of 2020, the Directorate was restructured into 3 core workforce divisions. These were; Workforce Planning and Development; Workforce Pay, Practice and Partnership and Workforce Leadership, Culture and Wellbeing. In responding to the pandemic, Health Workforce Directorate 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 (NHS Education Scotland) and higher education partners to address key strategic issues and risks around healthcare student placements
- Supporting the deployment of students into the Health Workforce

10. I was not a decision maker in relation to the overall Covid strategy. However, the Workforce modelling that was produced was a relevant consideration and assessed alongside other health science data in determining the capacity of the NHS to manage waves of the pandemic. As the pandemic progressed, this data improved and was used to inform strategic decision making beyond providing immediate information on the changing levels of absence in the workforce. Selected data and statistical modelling were shared, in confidence, with key stakeholder groups within Health and Social Care both by email and verbally within forum meetings. Absence data was provided initially in daily situation reporting which went to ministers. Over the course of the pandemic absence data and later modelling fed into a capacity and pressures briefing report which was used by government stakeholders. Data shared included but was not limited to; "Covid-19 Daily dashboard" – Public Health Scotland; "PPE Supply update" –NSS and "State of the pandemic presentation slides" – National Clinical Director. The data was used to provide information about the capacity of the health system and allowed a better understanding on system pressures which was a key part of discussions and decision making.

11. On joining the Directorate, it was immediately apparent that the work of the Directorate needed to be refocussed to almost exclusively resource COVID related activity. I drafted a high-level directorate plan [GR2/001 – INQ000360982] and repurposed resource across the Directorate to focus on Covid priorities for the Health Workforce and ensure effective and efficient communication within and out with the Directorate were maintained.

12. This was done at the same time as the Directorate moved to virtual working. In the early days, most of the meetings were done by teleconference. As the technology improved, we increasingly utilised virtual meetings. There were daily meetings with colleagues across Health and Social Care Directorates at official level (HSCMB, daily huddles with senior officials and Ministerial meetings etc). There were also weekly "Four Harms" meetings which often required pre-meetings with DG HSC Directors and senior clinicians (such as Chief Medical Officer or Deputy Chief Medical Officer). 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. 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 and updated on an ongoing basis. 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). A chronology of the key decisions on which Health Workforce was the lead directorate has been provided [GR2/002 - INQ000147408].

13. The Scottish Government's Health Workforce Directorate also facilitated existing tripartite partnership structures throughout Covid. These are the relationships which are maintained with key stakeholders working closely on issues which affect staff. These included the Scottish Partnership Forum, Scottish Workforce and Staff Governance Committee and the Scottish Terms and Conditions Committee. These forums included representation from the Scottish Government, NHS employers and Trade Unions. 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.

14. From the outset, we used WhatsApp to keep communications flowing across the senior directorate team, on a day-to-day basis. This was mainly to keep in touch with colleagues from a well-being perspective, checking in with each other and informal conversations. We also used messages to administer job sharing and to cover the 7 day working week. These messages have not been retained and in the majority of conversations the automatic deletion function of older messages was in use. However advice and decision making continued through the normal official communication channels with emails and submissions to Ministers, papers to decision making forums, notes, and actions taken of meetings. The Directorate continued with business-as-usual practices across risk, parliamentary business and ministerial correspondence. A number of work programmes involving the directorate and the health service were stood down by collective agreement. This was confirmed in a Director's Letter [GR2/003 – INQ000360983] issued in March. This only altered in the initial lock down period in 2020, where it was subject to collective agreement.

15. The multidisciplinary team within the Directorate was refocussed and new ways of working were put in place that enabled the team to function 7 days a week. This was utilised on an 'as and when required' basis, throughout the pandemic. To support this, the Directorate's staffing expanded by 50% over the period and additional staff were recruited with specific skillsets. Professional medical advisors working with the directorate provided a beneficial resource. Military personnel with logistical skills were also used during the initial stages of planning and the use of ex-military staff was needed for some of the wider operational delivery challenges on vaccines and test and protect.

Leadership across the NHS

16. On reviewing the existing structures for Partnership working as described previously with employers, trade unions and professional bodies I decided that an additional senior leadership group was needed that could meet frequently. The Workforce Senior Leadership Group (WSLG) [GR2/004 - **INQ000389186** was established on 23 March 2020. It was made up of members from both Health and Social Care, and its purpose was to:

- Inform, engage and take collective action on key issues identified that required 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; and
- Ensure timely feedback from NHS Boards and Trade Union/Professional Organisations for the WSLG to address key issues

17. The group continued to meet as frequently as appropriate sometimes daily through the phases of the pandemic, reflecting the nature of advice and engagement that was required. As we worked through the pandemic, the group expanded to cover both Health and Social Care Workforce. I chaired the group in an open and inclusive way. Membership expanded as it was critical that we worked in Partnership across Government we involved representatives from employers and trade unions, as well as Social Care representatives from Local Government through Convention of Scottish Local Authorities (COSLA), the social care sector and Chief Officers from Health and Social Care Partnerships. In line with the terms of reference this allowed engagement with local constituencies and for members to ensure their views were shared. Action logs and agendas were shared via email with stakeholders.

18. The initial meetings of WSLG were, not unexpectedly, challenging. This forum allowed concerns to be actioned immediately and efficient escalation of issues. For example, there were concerns about the provision of PPE and the level of protection available for both Health and Social Care Workers. This allowed Health Workforce to escalate these concerns with officials in the PPE Division and liaise with Chief Nursing Officer on PPE guidance and united National Services Scotland to provide regular updates on stock holdings. National Services Scotland was the National Board responsible for the provision of PPE, and the Chief Executive attended the WSLG to hear concerns, provide assurance and address issues raised.

Leadership across UK Government (UKG)

19. Following my appointment, I contacted the Director of Workforce in the Department of Health for England. We agreed that we would work together across the pandemic, sharing risks and issues on an informal basis as senior officials. Overall, the Health Workforce is devolved, so the decision making in relation to the Workforce was for Scottish Ministers. However, as much of the decision making in relation to NPIs flowed through from 4 nations discussions, we both found it helpful to have regular catch ups. These took place on a fortnightly basis with additional ad hoc calls if needed depending on the stage of the pandemic. These intelligence sharing catch ups were informal with no minutes.

20. To my knowledge neither I nor Health Workforce had any direct interface with the other devolved nations in respect to NPIs.

Decision making on NPIs

21. As mentioned above, in general as Director of Health Workforce I was making sure that consideration of decisions in relation to NPIs took account of any specific issues for the Health Workforce. I ensured that decisions made around NPIs for the workforce were effectively implemented. These issues were picked up and discussed through the WSLG arrangements. Depending on the nature of the issue, there were also roles for existing partnership mechanisms. For example, issues in relation to terms and conditions would be considered through the Scottish Terms and Conditions Committee (STAC). They covered areas such as developing guidelines for employees who were required to shield because of underlying medical conditions. Whilst in my previous role as Director of Safer Communities I was aware of discussions on how to best manage the spread of the virus. To the best of my knowledge the strategy being followed during this period was to seek to identify any, and all, suitable measures to limit the spread of the virus where possible, and to effectively deal with the anticipated consequences of likely widespread infection, including the impact that this would have on health service capacity. I was aware that the Scottish Government, via the Chief Medical Officer and others, were actively liaising with the other UK administrations and that the available scientific advice was being shared.

22. **National Lockdowns** - these did not have a specific workforce impact on the Health Care Workforce who were still required to attend work. Special arrangements were made for staff in the shielding category to take account of their specific risks. There was interim guidance issued specifically for Health and Social Care employers relating to staff from Black, Asian and Minority Ethnic backgrounds. Pregnant staff were directed to the Royal College of Obstetricians and Gynaecologists guidance. [GR2/005 - INQ000147439]. This guidance evolved over the period. I had no direct involvement with the decision to adopt a national lockdown. I was aware of the complex set of factors being considered and the nature of non-pharmaceutical interventions including lock down.

23. **Social Distancing** - there was significant work done with the Health Workforce to communicate where social distancing remained in place for them. Areas considered and specific advice given included breaks, car sharing and reminding staff that the restrictions applied outside of work.

24. **School Closures** - there was significant discussion with other parts of Government in relation to the decision to close schools, with decision making around who had key worker status and situations where one or both parents were key workers. It was difficult to reliably model the impact of absence although the data available fed into these discussions. The decision to open schools for the children of key workers was communicated through a Directors' letter on 3 April 2020. All NHS staff were considered either Category 1 or 2 key workers and were eligible for such provisions. As we started to understand the pattern of the virus and predict waves, we were able to forecast a peak around Easter 2020. This led to WSLG working with Education Scotland to ensure that sufficient critical provision was available over the Easter holidays to support key workers.

25. **Working from home** - policy and guidance was put in place to enable those who could work from home to do so and to make adjustments to roles, allowing those in the shielding categories to work from home.

26. **Self-isolation** - significant work was done to balance the needs of the provision of services to the public with appropriate self-isolation guidance. This was adjusted through the pandemic, as advice and understanding changed. A Directors' letter was issued to NHS Boards on the 14th July 2020 [GR2/006 – INQ000389185 with guidance around NHS staff returning to the UK from abroad. This included guidance around gaining approval before making foreign travel plans. Ongoing isolation guidance for Health and Social Care workers reflected guidance for the general population until 23 July 2021, when exemptions for Health and Social Care staff were introduced. These exemptions worked in conjunction with the staff testing policy that was in action at that point. In the development of the self-isolation exemption guidance, consideration was given to 'at risk' and clinically vulnerable groups.

27. **Use of face coverings** - there was significant and evolving understanding on the nature of face coverings required by the Health and Social Care Workforce. The Covid Risk Assessment tool was developed in a progressive staged approach, prior to the individual risk assessment guidance (published in July 2020). Trade Unions/Professional Organisations, NHS employers and Social Care organisations and representative bodies were involved in the development of the guidance through the Workforce Senior Leadership Group.

28. The risk assessment tool was used to address potential issues arising from at risk vulnerable groups.

29. As mentioned I was not directly involved in the decision making process relating to NPI's or the impact on vulnerable groups more widely out with Health Workforce. I therefore don't have a full understanding of the considerations of Scottish Government on the impact of NPIs on at risk groups out with my Directorate.

Data and Modelling

30. The modelling of the likely impact of Covid on Workforce availability was part of the broader consideration when deciding the further restrictions based on an assessment of the 4 harms in a locality. As we worked through the pandemic, it

became apparent that the single measure of Workforce absence was only one consideration in a much wider set of decisions about service provision and prioritisation.

31. From a Health Workforce perspective, the availability and sophistication of any modelling data evolved over the course of the pandemic. As the pandemic progressed, Workforce modelling was refined with the ability to draw more sophisticated understanding from the data. In the early part of the pandemic, the team were not making use of forecasting data (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 advise Ministers of actual absence levels across the service. Recording of coronavirus related absence (against a number of different categories, including caring responsibilities and self-isolation etc) was also undertaken. In general, Health Workforce absence mirrored the wider level of absence in the population, as the Covid waves worked through over the whole period. 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 forecast 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, 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 inform the suite of winter pressures workforce interventions over the course of the two years.

32. However, it also highlighted the limited capacity to 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. Clearly, the decision making before the advent of the vaccine was more challenging as the NPIs at this point were the only way of controlling the spread of Covid. As vaccines began to take effect, decision-making changed.

Overall, we took decisions and sought advice from a wider group of experts. For example, the Chief Medical Officer led on advice and decision making around shielding, NERVTAG and related groups made decisions.

Divergence

33. Overall, I was not aware of significant divergence between SG and UKG in relation to the Health Workforce on NPIs. In the initial stages of the pandemic, Health Workforce relied on the UK Government Pandemic Influenza Planning Guidance [GR2/007 - INQ000147423]. There was a good flow of data and information allowing policies to be implemented timeously based on the best evidence available. In general, as the pandemic developed, our approach and messaging did differ at times from the UKG. One example was the UKG's decision to add 1.7 million people to their Shielding/Clinically Extremely Vulnerable list, which resulted from their decision to deploy the risk stratification tool QCovid. Scottish Government liaised with UKG counterparts to check what they were planning to communicate around this, with the aim of minimising 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 individuals in Scotland who were in this category. There was also Scotland-specific messaging in relation to the face covering exemption card scheme which was unique to Scotland. Public messaging was relayed via our delivery supplier, Disability Equality Scotland, on behalf of Scottish Government with messaging around treating people with kindness, if they were unable to wear a face covering. As I was not directly involved in any divergence of national messaging I cannot comment on whether it was necessary. I have no reason to believe the national messaging was not effective.

Legislation and Regulations

34. In relation to the NPIs, there were no specific workforce related matters that needed to be addressed. Decisions in relation to the workforce were primarily dealt with by adjusting national workforce policies or terms and conditions and then communicating this via a directors' letter. This was made more straightforward as the NHS had been placed on an emergency footing, meaning

that we were introducing more national, 'Once for Scotland' approaches and policies.

Communications

35. In my role as Director of Health Workforce I was involved with the communications to health staff. For example, an internal NHS campaign "Kind to Remind" was launched on 24 May 2021 to encourage Health 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 health workers in staff only areas. I was not involved in the decision making related to wider public messaging which is handled through Scottish Governments Corporate Communications.

36. Engagement and communication of advice and guidance to the Health Workforce was subject to considerable discussion at the Workforce Senior Leadership Group. On areas where there was viewed to be non-compliance, consideration was given to whether this was best dealt with at local team level or with national messaging.

37. Given the significant restrictions placed on the general public it's very important that officials followed the rules they expect others to follow. It is appropriate that these should be enforced and where rules were broken by those in a position of trust the public should expect them to be held to account. The Scottish Government was consistent in its approach and as a senior leader I enforced the restrictions with my own staff.

Key Challenges

38. The pace and scale of decision making as we worked through the pandemic could feel overwhelming. Ensuring availability of staff to work 7 days a week, with rest days, took time to put in place and get right. As described, there were limits to the modelling data available which made early attempts to assess the workforce capacity challenging. For this reason the approach was taken to secure maximum additional resource through various channels. Receiving military support in March 2020 helped establish some new work practices and

supported wellbeing and resilience across the pandemic. Health Workforce Directorate also looked at ways to support students, while adding resource to the workforce. This included student placements where an opportunity to join the Bank of Health Workers was offered to students in January 2021. Before taking up their FY1 post, trainees took part in 4 days shadowing to better prepare them for their first training placement in an NHS Board setting. Due to impacts of Covid-19 on undergraduate placement experience, some students were feeling anxious about this step. In line with the other UK nations, SG funded 5 additional shadowing days for FY1s. This was not mandatory but was being encouraged as a positive opportunity.

39. Health Workforce was a key enabler and dependency within the Covid response. For that reason, it was a significant consideration for many wider policy developments that were required. Challenges in implementation arose as we balanced the needs of the crisis response with the requirement to continue to train and support the Health Workforce for the future. Input from employers, the higher education sector and trade unions was essential in maintaining future resilience.

40. Making sure that decisions made at a national level would work at a local level was a key consideration. At times, there had to be flexibility to enable services in remote and rural areas to function effectively. Taking account of local variation became an important part of the modelling and situational awareness reporting. Particularly as we moved through successive waves of the pandemic which had a more pronounced effect at different times on different health boards.

41. Virtual working took time to get right, with the right processes and ways of working that enabled collective decision making on key issues. This improved through the pandemic as we adapted to new ways of working and were enabled by better technology.

Lessons Learned

42. DG Health and Social Care undertook an initial, lessons learned exercise about its pandemic response from March to September 2020, which was published on

6 August 2021 [GR2/008 - INQ000147474). In addition, the Standing Committee on Pandemic Preparedness was established by the First Minister and met for the first time in August 2021. The Committee published its initial report on 30 August 2022. This report made recommendations based on insight from the overall response to the pandemic including areas of responsibility for DG HSC.

43. It was important that we established, from March 2020, a wide and inclusive senior forum where we could have challenging and constructive dialogue. I think this helped to make sure overall decision making was effective. It created trust and confidence in the trade unions with the actions of Scottish Government which helped provide assurance to the Health Workforce that we were doing everything we could to listen to them and respond in a timely way to any concerns raised. As the actions of this group were carefully recorded, it now provides a clear spine of issues as they were considered for Workforce across the pandemic.

44. With hindsight, policy and guidance would have been more accessible, if it had been brought together in one place for the workforce.

45. We learnt from the decision making around vaccines over New Year 2021 how important it was to keep our trade union colleagues fully informed, even where we had partial or emerging information. It was also important that information was shared through round table discussion so that views could be considered and captured. Creating and continuing to invest in meaningful collective leadership across SG, Employers and Trade Unions is a lesson we have continued to build on post-pandemic.

46. The nature and complexity of the decisions and choices created by the pandemic meant that strategic command capability that allowed decisions at pace and scale was important. It was also critical that staff could be deployed at pace and scale. The multidisciplinary nature of the decisions meant that bringing together the right advice and expertise to advise Ministers from day to day was critical. At the start of the pandemic, there was insufficient understanding of the duration of the emergency and understanding of the scale of staff needed to service a 24/7

response. Capturing the learning of both the number of staff and skills needed will be helpful to inform resourcing decisions for future pandemics. This is not just an issue for Scottish Government but is relevant across systems.

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: 16 November 2023