Witness Name: Angela Leitch
Statement No.: 2
Exhibits: 10
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF ANGELA LEITCH

I, Angela Leitch, will say as follows: -

1. Background, qualifications and my role during the COVID-19 pandemic

1.1 I was appointed as the first Chief Executive of Public Health Scotland (PHS) in September 2019. I commenced in post in November 2019, four months before Public Health Scotland (PHS) became operational on 1st April 2020. I resigned from PHS on 17th April 2023.

1.2 I worked for over 30 years in local government in Scotland before joining PHS. I have worked in senior roles in four local authorities, latterly as Chief Executive of, firstly, Clackmannanshire Council and then in East Lothian Council. I had eight years' experience as a Chief Executive prior to joining PHS and had led large, complex organisations to deliver efficient and effective public services.

1.3 My previous roles included:

- 1996- 2006 various Heads of Service positions within West Lothian Council.
- 2006-2009 Head of Service Edinburgh City Council.
- 2009-2011 Chief Executive Clackmannanshire Council.
- 2011-2019 Chief Executive East Lothian Council.

1.4 The attraction of the PHS role was the emphasis on the prevention of poor health outcomes and how a different approach could enable people to live healthier for longer and reduce the demand on health services. My experience was in line with the

qualities that PHS set out in the recruitment documentation. In addition to holding various leadership roles at a local level over several decades, I worked in a political environment both locally and nationally and delivered improved outcomes in conjunction with other partner organisations which would be a major feature of the PHS role. My national experience included being an Office Bearer with the Society of Local Authority Chief Executives in Scotland (SOLACE) for a number of years. I chaired SOLACE for 18 months and led, for several years, the branch's work on both children and families and on leadership and development for senior managers across local authorities. This work involved considerable engagement with civil servants and politicians in the Scottish Government. I also held a non-executive role on the Board of the Improvement Service for 5 years prior to starting with PHS and have held trustee roles for various charities.

1.5 I joined PHS with a firm understanding of the importance of public services such as education, early years, housing, good quality public spaces, a green environment, access to good quality food, jobs etc in improving outcomes for people and communities. I had developed strong relationships with partner organisations that worked with local authorities, and I also worked extensively across regional boundaries to deliver improvements in my area. Throughout my career I have had a firm focus on improvement, performance, efficiency and effectiveness.

1.6 As Chief Executive of PHS, it was my role to set the direction for the organisation and provide the strategic leadership to bring three distinct structures together to form a unified, focused and impactful public health capacity for Scotland. In managing multi – disciplinary bodies I am practiced in ensuring I use the professional skills within the organisation. I had a firm grasp of the context within which PHS was working in the period April 2020- April 2022 and as the responsible officer I ensured that PHS had the resources in the right place to provide advice and intelligence to decision makers. The clinical and medical expertise was provided by appropriately qualified senior staff throughout this time. These individuals provided direct advice to Scottish Government while I ensured appropriate levels of support and challenge.

1.7 I did not have any role in respect of the relationships and communications, including joint decision-making between the Scottish Government and the UK Government, or the devolved administrations in Northern Ireland and Wales.

1.8 As well as working with the Scottish Government, I worked with the umbrella organisation that represents local authorities, COSLA, and ensured appropriate PHS

staff supported different COVID-19 decision-making groups that involved local government. For example, Dr Diane Stockton was our COVID lead for children and education. Diane was a member of the COVID Education Recovery Group (CERG) which provided leadership and advice to Ministers and local government leaders in developing the strategic approach to the response and recovery of the Early Learning and Childcare and education system. CERG was co-chaired by the Cabinet Secretary for Education and Skills and the COSLA Children and Young People spokesperson. The group worked with the Directors of Public Health (DPHs), the Association of Directors of Education in Scotland, COSLA, Solace and members of the childcare, education and youth work sector to support the safe return of pupils to school. Our role in this group was to provide public health leadership, evidence and advice. Further detail on this group can be found within our Module 2A corporate statement, paragraph 6.3.8 **(AL/1 INQ000237820)**.

1.9 As PHS did not become operational until April 2020, prior to that, the national leadership to protect the Scottish public from infectious diseases such as COVID-19 was the remit of Health Protection Scotland (HPS), which was part of NHS National Services Scotland (NSS). In the lead up to PHS becoming operational, I worked closely with HPS between January and March 2020 to understand their functions. HPS, and then eventually PHS, was responsible for a range of work in relation to COVID, such as preparing guidance, providing data and advice and setting up a national contact tracing system. These responsibilities continued to change as the pandemic developed and we worked with senior civil servants throughout who in turn advised Scottish Ministers.

1.10 As noted in the Module 2A corporate statement beginning at paragraph 1.3.4, the NHS in Scotland was placed on an emergency footing on 17th March 2020, and this remained in place until 30th April 2022. This meant that Scottish Ministers had direction making and emergency powers to instruct NHS Boards, including PHS, to carry out certain actions. While I was active in many forums when issues were being considered in relation to the management of Covid-19, it was the practice that others from within PHS with specialist knowledge would also be in attendance, such as Dr Jim McMenamin, Incident Director, or Dr Nicholas Phin, Director of Public Health Science. As stated in paragraph 1.6, the operational work was delegated, and the experts from various fields, overseen by other executive or senior managers, would provide the advice to Scottish Government.

1.11 The groups/meetings which I attended during the period in question which may have impacted upon the Scottish Government's response to COVID are noted below in paragraphs 1.12-1.20. Further detail of these groups is also noted within the Module 2A corporate statement, beginning at paragraph 6.3:

1.12 The Scottish Covid-19 Advisory Group (SCAG):

1.12.1 The Scottish Government COVID-19 Advisory Group (SCAG) was an expert group chaired by Professor Andrew Morris, Professor of Medicine at the University of Edinburgh and Director of Health Data Research UK.

1.12.2 The group considered the evidence and applied the advice from SAGE and other appropriate sources of evidence and information to inform decisions in Scotland.

1.12.3 The membership was largely clinical/scientific people. I was invited to participate in SCAG on 25th March 2020. Initially PHS was represented on the group by me as Chief Executive and Dr Jim McMenamin, as Incident Director. Dr Nick Phin, Director of Public Health Science represented me as an observer on 19 November 2021 and was subsequently sent a personal invitation by the secretariat of the Covid-19 Advisory Group to attend meetings from 9th December 2021 and at that point I stepped down from the group.

1.12.4 As part of this group, I ensured PHS provided appropriate data, evidence and modelling to support discussions and advice that was subsequently submitted to Scottish Ministers.

1.13 The Mobilisation Recovery Group:

1.13.1 The Mobilisation Recovery Group was an advisory group established under Re-mobilise, Recover, Re-design, the Framework for NHS Scotland. It was chaired by the Cabinet Secretary for Health and Social Care.

1.13.2 The group's aim was to provide advice on health and social care policy and delivery in the context of the response to COVID-19, and to generate key expert and stakeholder system-wide input into decisions on resuming and supporting service provision, in the context of the pandemic. This included emergency care, diagnostics, cancer services, scheduled care, mental health, social, primary and community care.

1.13.3 I represented PHS on the group from July 2020 until the last meeting of the group which I believe was in April 2021. Other members of the group included representatives from COSLA, the Royal College of Nursing, the British Medical Association, the Royal College of General Practitioners, the Health and Social Care Alliance Scotland, the Care Inspectorate, and the Scottish Social Services Council. The group had a large membership - most meetings had over 40 people in attendance. Given the large number of people and agencies involved this group primarily ensured that information was provided on key topics and it was a forum where people could voice opinions. The meetings took place regularly, approximately every three weeks.

1.14 COVID Recovery Strategy Joint Programme Board

1.14.1 The COVID Recovery Strategy Joint Programme Board was a committee of senior representatives who oversaw the collaboration and joint work of the delivery of the COVID Recovery Strategy. It was jointly chaired by the Deputy First Minister and Minister for COVID Recovery, John Swinney, and the COSLA President, Alison Evison.

1.14.2 I was invited to join in December 2021 and attended my first meeting on 15 December 2021. My role on this group was to represent PHS and provide a population health perspective and advice on the delivery of the strategy. After December 2021, the group met again in March 2022 (I sent apologies and Scott Heald, Director of Data and Digital Innovation, deputised), September 2022 (I sent apologies and Elaine Strange, Head of Service, deputised) and January 2023 before my membership transferred to the new PHS Chief Executive, Paul Johnston. I believe the group has since been concluded.

1.15 Chief Medical Officer engagement:

1.15.1 Periodically I attended the Chief Medical Officer (CMO) Advisory Group. When the group first formed at the end of March 2020 I was invited to attend and represent PHS alongside Dr Jim McMenamin. I agreed to join and advised that I would review PHS membership on the group once I gained a better understanding of its role. The group met approximately twice per week to begin with, and I recall joining the meetings during April and May 2020. After that Jim continued to be a member of the group.

1.15.2 As stated beginning at paragraph 1.19, I was a member of the Scottish Government's TTIS Steering Group, of which Nicola Steedman, Deputy CMO, was also a member. As this work progressed into the Test and Protect portfolio, and PHS set up various groups to oversee and deliver contact tracing, I remained in occasional contact with Nicola Steedman as she provided Scottish Government insight on this topic. From time to time we would also interact around guidance, however that would only be when things had been escalated to me from colleagues.

1.16 First Minister engagement:

1.16.1 On occasion the First Minister would request a "Deep Dive" on a specific subject. I attended some of these sessions. After an initial presentation from a subject specialist, the First Minister and the Cabinet Secretary for Health and Social Care would question those in attendance on the detail of the issue. The first meeting of this nature that I recall was in May 2020 and it was to consider the operational model of contact tracing that would apply in Scotland. Together with a Public Health Consultant I explained in detail the proposed approach that had been developed in conjunction with the DPHs that were employed in the territorial Boards.

1.16.2 There was also an instance on 21st July 2020 where Dr Jim McMenamin and I were called to a meeting with the First Minister at very short notice. The First Minister explained that she required more data that would support her and her Cabinet in anticipating the development of the virus across different parts of Scotland. This hadn't been something that I or Jim were aware of until this meeting and I subsequently supported staff in the Data Driven Innovation Directorate of PHS to work with senior civil servants to develop systems which would provide greater insight into the changing patterns of the virus.

1.17 Cabinet Secretary for Health and Sport engagement:

1.17.1 The Cabinet Secretary for Health and Sport, Jeane Freeman, took a keen interest in the work of PHS and how the organisation was being established. I met with the Cab Sec on four occasions from memory. The first took place on 14th May 2020 on the Test, Trace, Isolate (TTI) Implementation. The second meeting was the following week on 22nd May 2020 to catch up again on the TTI implementation. On 6th August 2020 there was a meeting to discuss issues around the communication

between our two organisations. As these meetings were organised by Scottish Government, if there are notes of these meetings, they will be held by them.

1.17.2 In November 2020, I met with the Cab Sec and the COSLA sponsor, Councillor Stuart Currie for a routine discussion. The meetings focused on any emerging issues and further development on the relationship between PHS and its co-sponsors.

1.18 PHS sponsors:

1.18.1 PHS is unusual in that is a NHS Board which is jointly sponsored by COSLA and Scottish Government. However during the first two years of the new body being established I worked especially closely with the Scottish Government sponsors because of the nature of our work. PHS had a variety of different sponsors throughout that period. I worked with them all - Caroline Lamb, who was our sponsor before she became Director-General Health and Social Care, Jamie McDougall, Deputy Director, Elinor Mitchell, Interim Director-General Health and Social Care, Liz Sadler, Deputy Director Health Improvement Division, Richard Foggo, COVID-19 Director and Director of Population Health, and Michael Kellet, Director of Population Health.

1.18.2 As Chief Executive of PHS, I managed the change in sponsors over the course of the first couple of years. The reason for so many changes in our sponsor was due to Scottish Government staff being reassigned to different roles, usually to lead COVID-19 related work. In some cases, the long term absence of a civil servant necessitated a change. In particular I worked very closely with Caroline and Jamie on Test and Protect issues.

1.19 Test and Protect Groups:

1.19.1 On 4th May 2020, the Scottish Government published Covid-19: Test, Trace, Isolate, Support - A Public Health approach to maintaining low levels of community transmission of COVID-19 in Scotland **(AL/2 INQ000235141)**. The Scottish Government set up a Test, Trace, Isolate, Support (TTIS) Steering Group to provide leadership and oversight for the implementation of the strategy. Chaired by Elinor Mitchell, Interim Director General Health and Social Care in Scottish Government. The main purpose of the group was to maintain oversight of the design and delivery of the TTIS approach. I was a member of this group. My

recollection is that it only met as the TTIS Steering Group in May and June 2020 before it became known as the Test and Protect Steering Group.

1.19.2 Throughout April and May 2020, PHS were providing expert advice on the development of the contract tracing component of the TTIS strategy. We worked collaboratively with the DPHs to develop a locally delivered, nationally supported contact tracing service. We set up the Contact Tracing Oversight Board (CTOB) which I chaired. It met for the first time on 7th May 2020 and programme management support was provided by NSS. This group provided oversight and governance for the contact tracing programme. Throughout this period, we worked with NSS to deliver the National Contact Tracing Centre. The CTOB reported to the TTIS (Test and Protect) Steering Group.

1.19.3 PHS also established a Contact Tracing Implementation Group which was chaired by Scott Heald, Associate Director, and Professor David Goldberg. This group reported to the CTOB. The group was responsible for the delivery of the PHS COVID-19 Contact Tracing Programme's workstreams and projects.

1.19.4 We established a Contact Tracing Programme Core Team which was overseen jointly by Colin Sumpter, Consultant in Public Health, and Simon White, Programme Director at NSS. The Core Team oversaw the programme workstreams and projects and reported to the Implementation Group.

1.19.5 Once the new strategic approach became operational, I delegated roles to key PHS staff including Scott Heald, who was an Associate Director at that point in time, Colin Sumpter and George Dodds, Chief Officer. I retained an oversight of the work throughout. Further details are set out in our Module 2A corporate statement in paragraph 4.2.9 – 4.2.10 and in section 8.2.

1.20 Vaccination Groups:

1.20.1 As we worked with the Scottish Government, NHS Education for Scotland (NES), NSS, and local boards to design and roll out a population-wide COVID-19 vaccination programme, various groups were established. The overall responsibility for vaccinations remained with Scottish Government, but in-line with flu vaccinations, the vaccine readiness aspects (procurement of vaccines, logistics of delivery, PPE etc.) sat with NSS. NES are involved in-terms of training and education of vaccinators and the health workforce.

1.20.2 On the 23rd July 2020 I received an invite from Derek Grieve, Interim Head of Vaccines Division at Scottish Government, to join the Flu Vaccination Expansion & COVID-19 Vaccination Delivery Programme Board (often abbreviated to the FVCV Programme Board). Programme management support for the group was provided by NSS. The group met for the first time on 27th July 2020 and initially they met often, around every 2 weeks. The vaccination programme later split into three tranches of work (programmes):

- Tranche 1 – Current (FVCV) COVID Vaccination Programme.
- Tranche 2 – Autumn/Winter 2021 Flu Vaccinations and COVID Boosters.
- Tranche 3 – Structure and arrangements for delivery of ongoing 'business as usual' vaccinations in NHS Scotland.

1.20.3 I believe that the original FVCV Programme Board governed Tranche 1 and 2. In July 2021, Scotland's National Vaccination Partnership Portfolio Board (often abbreviated to the FVCV Portfolio Board) formed. I was invited to join and the first meeting was held on 7th July 2021. This Board formed to provide strategic oversight, direction and ensure delivery of the long-term future shape of vaccination services in NHS Scotland. It overseen Tranche 3 of the vaccination programme. These groups continued to be chaired by Scottish Government and supported by NSS.

1.20.4 The PHS role on these groups and sub-groups was to provide clinical advice and public health leadership on a variety of issues such as vaccine safety, vaccine confidence and consent, data and analysis, training and education, and marketing. My own responsibility at these types of meetings was to ensure the appropriate expertise from different teams across PHS was being harnessed to develop and deliver an effective vaccination structure that would protect all of Scotland's residents.

1.20.5 I continued to work closely with government officials, together with the Director for Clinical and Protecting Health, as the responsibility for vaccinations was transferred from SG to PHS. Once the vaccine roll-out began my PHS colleagues such as Dr Diane Stockton, Consultant in Public Health, Dr Claire Cameron, Consultant in Health Protection, Nuala Healy, Vaccine Confidence, Informed Consent and Advice Senior Responsible Officer, and Ruth Robertson, Workforce

Education Lead remained on the various groups and had responsibility for specific aspects of the programme.

2. Initial understanding and response to COVID-19 (January – March 2020)

2.1 PHS was not operational in January-March 2020 therefore I, nor my organisation, provided any advice to Scottish Government on the use of a lockdown during that time or on the initial strategies that they wished to implement. I do recall that the first lockdown was applied across the whole of the UK. We set out in the PHS Corporate Narrative **(AL/3 INQ000147528)**, beginning at paragraph 6.5, and within section 2 of our Module 2A corporate statement, an overview of the contribution made by the organisation to respond to the pandemic.

2.2 As PHS was not operational until April 2020 I was not involved in any discussions or advice prior to then regarding testing capacity. I am aware that between Jan-Apr 2020, colleagues in the Public Health Microbiology team within HPS who would go on to become PHS employees, were involved in testing preparedness. This involved working with the laboratories to ensure they had the support required to develop testing. The team at HPS worked closely with PHE over this period to ensure plans for testing in Scotland were aligned with England and the other nations. The team at HPS established a Laboratories and Diagnostics Cell to facilitate the strategic coordination of laboratory services in line with public health need, focusing on, and in collaboration with, Specialist and Reference Laboratories as part of the clinical response to COVID-19 across Scotland. The work of this cell moved from HPS into PHS in April 2020 and continued throughout the pandemic. Dave Yirrell, Consultant Clinical Scientist in Virology, and Michael Lockhart, Consultant Microbiology, were the co-chairs of the cell. I understand that there was an emergency meeting in mid-March 2020 to discuss laboratories capacity given the expected demand in PCR testing however I did not attend this meeting.

2.3 In January 2020 I had arranged to spend time with Duncan Selby, who was Chief Executive of Public Health England (PHE) at the time. I had been appointed to the role of Chief Executive of PHS at that point, but the organisation was not operational yet. I arranged to visit PHE to gain an understanding of how that organisation operated. While I was with PHE, it was obvious that the organisation was in discussion with the UK Government in relation to a virus that was prevalent in China. I raised the issue on my return with the clinicians who would transfer to PHS, Dr Jim McMenamin, Professor David Goldberg and Dr Colin Ramsay, who were alert to this

threat. NSS continued to liaise with colleagues in other parts of the UK on all issues until April 2020 when PHS was formed. NSS retained responsibility for certain matters, such as setting up testing laboratories.

2.4 Through my visit to PHE, I became aware of the work being undertaken by PHE at a very early stage and the ongoing engagement between them and senior civil servants and Government ministers. In terms of what was happening in Scotland, I was not involved in any discussions with the Scottish Government around the seriousness of the threat until around March 2020. I was aware that colleagues in HPS were involved in ongoing discussions about the virus before I was, particularly as we began to see the first cases in Scotland in March 2020.

2.5 When PHS launched on 1st April 2020, it was eight days into the first UK lockdown. We began to see the benefits of the creation of one unified public health agency. The Senior Leadership Team of PHS brought together experts in health protection, data and intelligence, health and wellbeing, and organisational governance. As the staff who joined from HPS were already leading the national health protection response, working with colleagues in Information Services Division around the data infrastructure and reporting, we quickly mobilised the staff from NHS Health Scotland into supporting the pandemic related work. This happened at speed and with minimal obstacles in terms of human resources processes by dint of everyone being part of one organisation.

2.6 As referenced in my Module 1 witness statement **(AL/4 INQ000185335)**, paragraph 5.3, the Director of Population Health in the Scottish Government made it clear to me that additional funding would be provided and that concerns around resources should not be a hindrance to the effective delivery of the pandemic response. While this funding was provided following submission of a business case in October 2020, the skill sets that were needed were in great demand across the country. While we continued to recruit to new temporary roles that the new funding allowed PHS also relied on redirecting existing staff to cover Covid-19 work.

2.7 In the period January to March 2020, I was aware that there was close collaboration between Scotland and other jurisdictions. As the pandemic developed the devolved administrations including the Scottish Government focused on responding in ways they believed would best support citizens. These decisions were based on the data and evidence available at the time. This virus was something that no government had experienced in living memory and while there will be many views of what should have

happened, I believe that the decisions were made in the belief that measures would safeguard the people of Scotland. While measures differed, the Scottish government like other parts of the UK was keen to learn from the experience of others to protect the health and wellbeing of individuals. I do not know if the Scottish Government was curtailed by the UK Government at any point.

2.8 I am unsure to what extent the concept of "herd immunity" was considered as a Strategy by Scottish Government. The term was not used at all by PHS throughout the pandemic, it was not something that I recall being seriously considered within PHS. There were discussions about containment and tracking. In the early stages of the pandemic, there was a lot of work undertaken by the teams in HPS trying to trace people that they thought had contracted COVID-19. It was mainly people who had been hospitalised because at that point there was no widespread testing and we had seen an increase in the number of hospital admissions.

2.9 I am aware that there were two large events which went ahead in Scotland at the end of February 2020 (the NIKE conference) and the beginning of March 2020 (Scotland vs. France Six Nations Rugby). I did not take part in any discussions with the Scottish Government prior to these two events taking place. PHS did undertake follow up work on the NIKE conference. PHS were alerted by international public health authorities that someone had tested positive following attendance at a conference (which I now understand to have been the NIKE conference) in Edinburgh. As a result of this, we set up and led an Incident Management Team (IMT) of experienced public health professionals to assess and investigate the incident. This included contacting all conference attendees to give appropriate public health advice. PHS undertook analysis of molecular sequencing of the strains of the virus in Scotland, including the one associated with the conference. We produced a consensus IMT report in October 2021 which is available on the PHS website, 'Incident Management Team Report Conference Outbreak – March 2020' **(AL/5 INQ000147544)**. The report concludes that the strain associated with the conference accounted for only a minority of detections in Scotland, and from April 2020 the strain had been eradicated. This work is referenced in our Module 2A corporate statement, paragraph 4.5.2.

3. My role in relation to non-pharmaceutical interventions (NPIs)

3.1 Within PHS, there was a considerable redeployment of staff to enable the organisation to respond to the new requirements. The organisation had to expand (where we could) the clinical advice that was required – initially from HPS, and then

PHS. I worked with the teams that I inherited and looked at what the skills required were and how we could best move people into roles which would enable us to set up systems to provide information, provide daily briefings/updates on numbers of Covid cases and numbers tested.

3.2 The willingness of people to adapt and acquire new skills and work with new teams worked well. Frustrations were experienced around the technical inadequacies at the outset of the pandemic to be able to quickly provide the new data and information that was needed. As can be seen from the Corporate Narrative and the Module 2 statement, the organisation was in constant dialogue with individuals in other organisations. I had daily contact with Scottish Government staff, some in local government, other NHS Boards and key agencies such as Police Scotland.

3.3 As Chief Executive of PHS I ensured the organisation provided data, intelligence, advice and guidance throughout the pandemic. I delegated responsibility for certain work to key members of the team and regularly reviewed performance and progress with the main projects. The names of individuals responsible for the work are provided in Appendix C of our Module 2A corporate statement. The work of staff in PHS across these areas is set out in the Module 2A Corporate Statement, with section 2 providing a good overview and more detailed information available throughout.

3.4 Under my leadership, staff in PHS contributed to a range of different strategies and NPIs to address the impact of COVID-19, including:

3.4.1 The surveillance of COVID. I ensured adequate resources were available for this work as well as ensuring the development of effective systems. We produced daily reporting which was shared with the Scottish Government and used by the First Minister. We worked with a range of colleagues in Scottish Government and a range of teams in local boards to make sure the data was as accurate as it could be and provided on a timely basis. Reporting on COVID testing and COVID numbers evolved over the period of the pandemic. Initially our systems relied on personnel and over time more were automated pulling the information from the Boards and being able to aggregate it, providing it to government with assurance that it was accurate. My role was very much one of direction, support, encouragement and leadership.

3.4.2 PHS also provided advice in relation to school closures. I reference in paragraph 1.8 the work of CERG. I created the capacity within the organisation to advise on

school closures and how to support children through the lockdown period as far as their education was concerned. I put together and reviewed the work of the small team that was dedicated to giving that advice to Scottish Ministers. Throughout the pandemic PHS supported decision-making around whether schools should be open to pupils. Evidence from the programme of enhanced surveillance of COVID-19 in educational settings helped inform the development of educational policy. Further details can be found in our Module 2A corporate statement, beginning at paragraph 6.3.6. We were also members of the Scottish Government sub-group on Education and Children's Issues. Dr Eileen Scott, Public Health Intelligence Principal, represented us on this group. This group advised on things like face-coverings in education settings.

3.4.3 As stated in the PHS Corporate Narrative, paragraph 6.5.15, PHS led on the analysis of testing data from care homes, working with local Boards, who were at the time leading on enhanced outbreak investigation in care homes. We worked closely with the Scottish Government, DPHs and the Care Inspectorate both on an advisory basis and through membership of a number of groups focussing on the care home outbreak. I, nor PHS, played any role in the decision to discharge patients from hospitals into care homes – we did not provide Scottish Government with advice on this matter. We were commissioned by the Cabinet Secretary for Health and Sport to carry out the analysis of the impact of this decision and this led to the development of a report on which we worked in partnership with Edinburgh and Glasgow universities. The report, 'Discharges from NHS Scotland hospitals to care homes[1]' **(AL/6 INQ000147514)**, was provided to Scottish Government in October 2020 and published on our website.

3.4.4 We provided guidance, which continued to be updated as the situation evolved, for health protection teams and healthcare practitioners, as well as setting specific guidance for non-healthcare settings including schools, places of detention, and care homes.

3.5 Dr Jim McMenamin chaired the National Incident Management Team's (NIMT). The NIMTs key function was to provide strategic public health leadership and advice to Scottish Government Ministers on measures to control the pandemic. The NIMT reports to the Scottish Government through the provision of written advice from the NIMT Chair following its meetings. PHS had the role of chairing and providing

[1] PHS. Discharges from NHS Scotland hospitals to care homes between 1 March and 31 May 2020. October 2020.

secretariat for such meetings. In addition, representation of other PHS staff on the NIMT reflected certain standing agenda items on epidemiology, national testing, risk assessment and response, and guidance. There were also contributions from PHS colleagues leading on education, communication, immunisation and the evaluation of the effectiveness of vaccination. The written advice provided to Scottish Government would be used by officials to support decision-making on NPIs. Further information on the NIMT can be found within section 4.3 of the Module 2A corporate statement.

3.6 The Scottish Government's approach to decision-making was to balance the Four Harms associated with COVID-19. PHS's Clinical Response and Guidance programme focussed on the direct health harms associated with the pandemic according to Scottish Government policy and regulations, while the organisation's Social and Systems Recovery (SSR) programme assessed and advised on the wider (non-viral, non-healthcare related) population health consequences of COVID-19.

3.7 We set up a steering group for the SSR programme, which included representatives from health boards, academia, COSLA and the third sector. The aim was to work with national and local policy makers to identify immediate, medium and long-term mitigation priorities and feasible mitigation actions in relation to wider population health impacts. PHS worked in collaboration with representatives of the steering group throughout the pandemic to consider evidence about the implications of the Scottish Government's strategic approach to managing COVID-19. Discussions took place around the NPIs and their impact on inequalities and there was substantial debate about the scale of the health harms resulting from lost employment, disruption to education, and social isolation, and how this compared to the benefits from lower COVID-19 transmission.

3.8 The SSR programme was led from within PHS by colleagues with expertise in health improvement and the reduction of health inequalities who had joined PHS from NHS Health Scotland. As set out in paragraphs 4.1.9 – 4.1.12 of the PHS Corporative Narrative, NHS Health Scotland had worked for 17 years to improve health through work on the social determinants of health, including supporting Scottish Government decision-making with regards actions effective in reducing inequalities. Section 9 of the Module 2A corporate statement provides detail of the work we carried out which considered the wider harms and impact of NPIs. A couple of examples include:

3.8.1 The national and local work on the reopening of schools which I reference earlier in this statement (paragraphs 1.8 and 3.4.2) also considered the broader impacts of the closure and reopening of schools on the health and wellbeing of children, young people, parents and education staff. PHS conducted 'COVID-19 Early Years Resilience and Impact Surveys (CEYRIS)' **(AL/7 INQ000189101)**, which explored the experience and impact of COVID, and the associated restrictions, on young children, 2–7-year-olds, in Scotland. PHS published a series of reports[2] covering key behaviours, children's play and learning, use of outdoor spaces, social interactions, and the experience of parents and carers. I am not aware of what impact this work had on Scottish Government decision-making.

3.8.2 In May 2020 we launched a dashboard on the wider impact of COVID-19 on the healthcare system which provides a high-level overview of how the pandemic is impacting more widely on health and health inequalities. The dashboard includes data on hospital admissions, A&E attendances, cancer services, excess mortality, and mental health. This was a publicly available dashboard and Scottish Government were given pre-release access before it was published online. This may have influenced their decision-making.

3.9 I am not aware of what consideration the Scottish Government gave to 'at risk' and other vulnerable groups, on the impact of NPIs. I am aware that the Scottish Government established an Expert Reference Group on COVID-19 and Ethnicity in June 2020 to consider and inform its approach in relation to the impacts of COVID-19 on minority ethnic communities, however this was after the first national lockdown. I ensured PHS was represented on this group and provided advice where necessary, produced data and evidence, and published reports such as the 'Monitoring ethnic health inequalities in Scotland during COVID-19'[3] **(AL/8 INQ000203066)**. Further detail is available within paragraphs 9.12.6 – 9.12.11 of the Module 2A corporate statement.

3.10 PHS published five reports outlining analysis of variations in outcomes by ethnic group of those who have tested positive for COVID-19, starting on 20th May 2020. The availability and completeness of data was a challenge but, based on the available data, we found that the proportion of ethnic minority patients among those seriously ill with COVID-19 appeared no higher than the relatively low proportion in the Scottish

[2] PHS. COVID-19 Early Years Resilience and Impact Survey (CEYRIS). Latest release January 2022.
[3] PHS. Monitoring ethnic health inequalities in Scotland during COVID-19. Latest release March 2021.

population generally. We were clear that further work was required to improve the data and conduct further analysis over a 10-month period. The fifth and final updated analysis of COVID-19 outcomes by ethnic group[4] **(AL/9 INQ000147523)**, which was published by PHS on 3rd March 2021 included a comparison of the impact between the first and second wave of the pandemic. The results provided evidence of increased risks in some ethnic minority groups, which persisted during the second wave, rising to around a three-fold increase in risk for some ethnic groups. PHS found that while rates of hospitalisation or death were higher during the second wave across all of Scotland's population, those of South Asian ethnicity appear to have been at proportionally greater risk. Further detail is available within paragraph 9.12.1 – 9.12.5 of the Module 2A corporate statement.

3.11 It was important to PHS that there was a high uptake of vaccinations in minority ethnic groups, and we began to report on this in March 2021 within our weekly report. It did show that uptake was lower in specific minority ethnic groups than it was for white population groups. This led to tailored messaging to increase vaccine confidence and uptake within this group.

3.12 As referenced above in paragraph 2.1, PHS did not offer any advice of guidance in relation to the first lockdown as we were not operational at that time. In relation to the second lockdown in January 2021, the Kent variant was becoming the dominant variant at that time and data was showing it was more transmissible than previous variants. The decision to introduce the second lockdown was one for the Scottish Government Ministers to make on the basis of advice and guidance provided by several organisations and experts. There are many views on the timeliness of the measures introduced during the period of the pandemic by those not in the position of making these critical decisions. I believe elected representatives reviewed the evidence and options and took action based on a collective view. Each NPI had consequences and going into lockdown earlier might have saved some lives at that point in time. However, what we are still to understand is the long-term impact of lockdowns on, for example, our children who were unable to attend school or socialise as they would normally.

4. Divergence

[4] PHS. Updated analysis of COVID-19 outcomes by ethnic group. March 2021.

4.1 As a devolved administration the Scottish Government took advice which enabled them to respond to the needs of the diverse communities across Scotland. I am aware that the approach taken by the Scottish Government differed from that adopted by the Westminster Government from around June 2020. The rules that applied to residents in Scotland started to diverge at that point. For example, our easing of restrictions after the first lockdown was slower than England. This would apply to things such as how many households could meet up at any one time or per day, if these meet ups were allowed to be inside or if they must be outside only, travel radius allowed outside of your home etc. The exact details will be able to be covered by others employed by PHS. By way of background, as the leader of PHS, I ensured that appropriately qualified staff were providing advice to senior civil servants. I also ensured that advice was coordinated across the diverse range of teams that were involved in different aspects of responding to and managing the pandemic. From the outset when PHS was formed as a legal entity, staff were providing advice to Scottish Government and senior civil servants.

4.2 In my view, as a devolved administration, it was entirely up to the elected politicians to make decisions on actions that were required to safeguard the people of Scotland. It's difficult to determine if divergence came at the right time. I think the Scottish Government listened to the best advice available at the time and believed the action they took was in the best interest of Scottish people.

4.3 By way of general comment, it is difficult to comment on when a divergent approach taken in Scotland worked well or when a four-nations approach may have worked better. In my view, we took the action that we did, and we did our very best to safeguard the public's health. It is difficult to comment on whether an alternative course of action would have resulted in a better outcome. For example, there are some who suggested that Britain should have gone into lockdown earlier. However, there are associated harms to consider with lockdowns such as the impact on children and young people's education, mental health and wellbeing and the impact to our economy. There are always consequences for any action, and these, I understand, were considered as part of the decision-making process.

4.4 One area where Scotland did diverge from the UK Government was around travel restrictions and border control. Border control and restricted entry guidance were set by the UK Government during the pandemic as a reserved matter. A UK-wide approach to International Travel Regulations was taken at the outset of the pandemic,

although this diverged as Scotland made different decisions in relation to the countries to which entry restrictions would apply. PHS and the Scottish Government worked closely in liaison with the UK Home Office and UKHSA with regards to International Travel Regulations. This also involved working closely on aspects such as flight contact tracing, border health monitoring, Passenger Location Forms and guidance to travellers (including quarantine and self-isolation). This is covered in more detail in the Module 2A corporate statement, beginning at section 8.4.

4.5 In terms of effectiveness and efficiency of divergence from the UK Government's approach, the one area I would point to would be contact tracing. Scotland had a more inclusive approach. A combination of national and local teams working together to support people who tested positive enabled public bodies to provide financial or any other support needed by individuals. It also meant that the more complex cases would be dealt with by the relevant local board, utilising their years of health protection experience.

5. My role in relation to medical and scientific expertise, data and modelling

5.1 My role in relation to providing medical and scientific expertise and advice, and data and modelling information was a leadership one. I ensured PHS had resources and systems in place to ensure the organisation could provide what was required. Scott Heald, Director of Data and Digital Innovation, had the overall role of providing accurate data as he was the Head of Profession for Statistics. It was public health professionals who were providing the advice to Scottish Government. Often this was Dr Jim McMenamin through the NIMT, or by our other Strategic Incident Directors, Professor David Goldberg and Dr Colin Ramsay.

5.2 Internally I worked closely with NHS NSS our technical and IT supplier to ensure our systems were effective and were capturing data appropriately. The systems, data collection and modelling were overseen by Phil Couser, Director of Data Driven Innovation, before he retired, and then by Scott Heald who was appointed as interim Director of Data and Digital Innovation (DDI) in June 2021.

5.3 As referenced above in paragraph 3.1, I ensured priorities were clearly set and resources deployed accordingly. There was considerable demand for the provision of data on a range of different fronts so resourcing that area with suitable skills was key. Modelling and predictions were key for Scottish Government in relation to their strategy and tactics. It was an intensely busy time. People were being moved from

hospitals to care homes and there were high death rates in the elderly population. There were lots of different aspects to resourcing and the data and medical advice we were being asked to provide.

5.4 At an early point in the pandemic, I worked with Scottish Government and local government to support the setting up of a system to record deaths over the weekend. As Registration Offices are closed over the weekend, deaths are usually not reported to Registrars until Monday which meant a delay in reporting deaths. Scottish Government was keen to report deaths accurately on Monday morning, so I worked with local and Scottish Government to enable funding to be provided to pay staff to work over the weekend for a temporary period of time.

5.5 The country was responding to the unknown. We used data and evidence to the best of our ability to advise Scottish Government on strategies they could take. That changed continually as the virus developed and moved through the population. As a leader, my role was to look at the challenges and, with staff, formulate proposals that decision makers could consider.

5.6 In terms of what I think worked well, from a PHS perspective staff were mobilised to develop new systems/processes to gather the data required, as referenced earlier in my statement (paragraphs 3.1 and 5.3). The responsiveness of individuals and the degree of collaboration that took place throughout the different phases of the virus were a real success. As the pandemic unfolded, PHS benefitted from the wider skills sets within the organisation and became much more efficient in gathering information and synthesising it in a way that was less labour intensive. Given the demands on PHS to produce data, we performed well in meeting daily deadlines and developing our predictive analytical capacity.

5.7 I cannot comment on whether Scottish Government was in any way restricted or prevented from understanding the full scientific picture. I know that PHS provided all that we could in terms of scientific data as did other institutions and groups. These groups are noted in our Corporate Narrative under paragraph 6.5.3, and in section 6 of the Module 2A corporate statement. The ones which I was part of are mentioned earlier in this statement. We provided as much of an understanding of the scientific picture as possible.

6. My role in COVID-19 public health communications

6.1 Under the emergency powers of the UK Coronavirus Bill, public health communications were reserved to Scottish Government. Communicating aspects of the COVID response that involve Ministerial decision-making was the responsibility of the Scottish Government. This included messaging relating to restrictions, Test and Protect and the vaccination programme, and taking any necessary action to combat any impact on clarity of messaging because of different approaches in other parts of the UK. This meant that most of the public health communications regarding COVID came from Scottish Government. If PHS wished to put something in the public domain in relation to COVID, it was processed through the agreed Scottish Government channel. We provide further detail of our role in public communications within our Module 2 Corporate statement, beginning at paragraph 10. In terms of behavioural management, Stephen Reicher of St. Andrews University was a Professor of Psychology and a member of the Scottish Covid-19 Recovery Advisory Group (SCAG) that I reference earlier in this statement. He provided advice and insight on behavioural management.

6.2 Many of the Government communications were based on PHS advice, but the Scottish Government officials directed and managed the communications. It is the political prerogative to take advice and then determine which parts to adopt. The advice PHS provided was continual, daily and on multiple subjects. My allocated leads provided ongoing advice on behalf of PHS. I would not have expected to approve operational correspondence. As a leader I ensured we had the professional advice and capability to make sure we could work constructively with Scottish Government.

6.3 I think by and large the public felt well informed. The daily briefings provided by Scottish Government were widely viewed by people across Scotland and covered in a range of media. The daily dashboard was very popular and was used daily by the First Minister in her briefings. As the pandemic progressed, we provided other information on for example, vaccine uptake. That also became a trusted source of data. There was a large degree of public confidence in data and in PHS. That was borne out by a YouGov survey conducted in February 2022. This was a public polling of 1001 Scots which we used to ascertain the baseline level of awareness of PHS. The survey found that 80% of people had heard of PHS and 84% of them trusted the organisation.

6.4 The training given to people who were testing and tracing was thorough and consistent, ensuring a degree of consistency for the public. Section 10 of our Module 2A corporate statement provides an overview of public communications.

6.5 As referenced above in paragraph 3.4.4, we were also producing guidance for health protection teams and healthcare practitioners, as well as setting specific guidance. Guidance was being continually updated in-line with the current situation. We had a process that we were required to follow before issuing guidance which was the Policy Alignment Check (PAC process). This required PHS to send new or updated guidance to a team within Scottish Government who then consulted the CMO before approval. Depending on the guidance, sometimes the Cabinet Secretary for Health and Social Care asked to see the guidance before it was issued. The guidance team at PHS dealt with the updates and PAC process. It was only when the PAC process slowed down and caused delays to PHS issuing guidance in a timely manner that I would liaise with our sponsors to reach a resolution. You can read further detail of the PAC process within our Module 2A corporate statement, beginning at paragraph 4.4.4.

6.6 I believe that it is likely the events that have been reported recently, after the pandemic, could have adversely affected public confidence in the UK Government. In the early stages of the pandemic there were a few indiscretions by individuals within Scottish Government which were dealt with swiftly, therefore it's my view that they had minimal impact on public confidence in Scottish Government.

7. Role in public health and coronavirus legislation and regulations

7.1 While PHS supported the development of legislation through the provision of evidence, we did not have a role in the formulation of legislation or in the enforcement or surveillance of compliance with the legislation and regulations over the course of the pandemic. PHS provided advice and guidance based on data and evidence which may have been used by civil servants to shape legislation where that was appropriate.

7.2 In many cases PHS provided briefing documents to civil servants as part of the briefing provided to Ministers. This may have then gone on to influence legislation. PHS frequently presented on the data and evidence at meetings. The Scottish Government would usually set the agenda for the meeting, identify the matters for discussion or decision, and communicate the implications of the decisions to be made

to Ministers and other decision-makers. In some cases, the agenda and matters for discussion would be informed by discussions that had taken place with PHS, and in other cases on the basis of advice from the NIMT or on the basis of input from expert advisory groups. I note earlier in this statement (beginning at paragraph 1.11) which expert advisory groups I was a member of. Some examples of specific ways in which we may have influenced COVID regulations which I believe worked well include:

7.2.1 Our continuous development and review of guidance. There were some issues at times with the PAC process that I reference earlier in this statement in paragraph 6.5. These are also referenced in paragraph 4.4.7 of our Module 2A corporate statement.

7.2.2 We contributed advice through our membership on the Scottish Government's Advisory sub-group on Education and Children's Issues and CERG. Our input to these groups would have made a difference to the consideration for further closures and restrictions within schools/education settings. Our work with these groups is noted earlier in this statement in paragraphs 1.8 and 3.4.2 and detailed within our Module 2A corporate statement, beginning at paragraph 6.3.6.

7.2.3 PHS's evaluation of the shielding programme and the evaluation of the COVID-19 vaccination programme supported decision-making around the pandemic. You can read more on this in our Module 2A corporate statement, paragraphs 4.8.3 – 4.8.13.

8. Key challenges and lessons learned

8.1 At my request, PHS undertook an internal lessons learned from COVID-19 exercise. We produced a report which summarises what we considered worked well and where we feel things can be improved. It has been submitted to the Inquiry and is also publicly available on the PHS website **(AL/10 INQ000187754)**. I, alongside many others, contributed to this. There was a lot of work to pull it together with operational staff. I considered our response from a strategic level providing an understanding of the complexity of setting up a new organisation in the pandemic and mobilising staff to respond to changing circumstances. Appendix 1 of the report has a series of actions that PHS are taking forward as a result of the lessons learned exercise. I was not involved in any external lessons learned exercises.

8.2 While the lessons learned report that I mention in the paragraph above was an internal report and therefore focuses on what PHS will address as an organisation as a result of lessons learned from COVID, there are some areas which will also be relevant to external organisations, such as Scottish Government. I've included a couple of examples of this:

8.2.1 To better prepare for any future pandemics, PHS will develop our concept of the operations and response plan to enable us to roll out a programme of incident management training for senior staff and all staff involved in health protection.

8.2.2 PHS has committed to reviewing the lessons learned in relation to data sharing and will work with partners to make improvements for future work – this action will require input from Scottish Government and the other Boards.

8.3 An area that I feel was a challenge and could be improved was in relation to the systems and procedures applied across the NHS in Scotland. They can be time consuming to implement and in an emergency situation could be a barrier to flexibility. Streamlining these could benefit not only the response in critical situations but a greater agility in general.

8.4 I reference in paragraph 6.5 the PAC process implemented by Scottish Government on guidance, and how at times this process could result in PHS not issuing guidance in what we considered a timely manner. Another issue to note with the guidance process was that due to the emergency powers (referenced in paragraph 1.10), PHS could offer advice on the wording of guidance documents, while Scottish Government ultimately decided what was issued. Previously, before these emergency powers were put in place, PHS would have held the lead role for offering public health advice. There are considerations to be made by Scottish Government and the relevant parties in PHS on how well this worked and if this is the course of action to take in any future public health pandemics.

9. Information communications and documents

9.1 In November 2021, PHS staff were formally notified that they must preserve all documentation relating to COVID-19 for the Scottish and UK Public Inquiries. This covered files, documents, emails, notes, text messages and WhatsApp. This means

that all of my emails have been retained and are available for reference. I am aware PHS are in the process of searching my inbox and submitting emails which are relevant to our Module 2A corporate statement.

9.2 The meetings that I attended which I reference earlier in this statement beginning at paragraph 1.11 were often followed up with a minute therefore these can be obtained by the organisation who provided the secretariat if required. Any notes that I captured whilst in meetings were about things we or I needed to do in organisation – the PHS actions. I did not ever record my own or anyone else's views within notebooks.

9.3 I participated in the COVID Outbreak WhatsApp Group which has been submitted by PHS previously as part of the corporate evidence. I did not participate in any other WhatsApp or messenger app groups which discussed advice for Scottish Government or contributed to decision making during the pandemic.

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: 06/10/2023