Witness Name: Dr John Harden
Statement No.: 1
Exhibits: JLH
Dated: 3 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR JOHN LINDSAY HARDEN

In relation to the issues raised by the Rule 9 request dated 20th June 2023 in connection with Module 2A, I, John Harden, will say as follows: -

1. I am Dr John Lindsay Harden from the Scottish Government, St Andrew's House, Edinburgh, EH1 3DG. I am the Deputy National Clinical Director (DNCD) reporting to the National Clinical Director (NCD), Professor Jason Leitch, and work to provide support to the NCD and further additional clinical input and leadership both on a national basis and within the Scottish Government's Directorate for Healthcare Quality and Improvement, within the Director General for Health and Social Care.

2. I have worked in Scottish Government since October 2016, initially as the Clinical Lead for Quality and Safety before taking up the post as DNCD in October 2020. I am also a practicing Emergency Medicine Consultant in NHS Lanarkshire.

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 [JLH/number - INQ000000].

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

1.1 As Deputy National Clinical Director (DNCD) my current remit includes:

- Deputising for the National Clinical Director, Professor Leitch,

- A member of the senior leadership team of the Healthcare Planning and Quality Directorate,
- Patient Safety and the improvement of healthcare quality,
- Long-term conditions including Long-Covid and Cancer,
- Supervision of the Scottish Clinical Leadership Fellow attached to the directorate each year,
- Supporting clinical engagement across the directorate.

1.2 I was initially appointed to the role of Clinical Lead for Quality and Safety in October 2016 and continued as this until taking up the interim DNCD role in September 2020. I am employed by Scottish Government on a Service Level Agreement (SLA) from NHS Lanarkshire. Prior to October 2016, I was a full time Consultant in Emergency Medicine at University Hospital Wishaw, NHS Lanarkshire. I continue to practice clinically on a one day per week basis in the same Emergency Department.

1.3 My qualifications are a Bachelor of Medicine, Bachelor of Surgery degree (MBChB) from the University of Glasgow. I am a member of the Royal College of Physicians and Surgeons of Glasgow and a fellow of the Royal College of Emergency Medicine. I am also a Scottish Quality and Safety Fellow.

1.4 I note that the request for this statement was to me in the role of "Former Covid Clinical Director". As stated above, my formal job title was, and remained as the Clinical Lead for Quality and Safety until my appointment as the Deputy National Clinical Director. The "Covid Clinical Director" title was never a formal title, and it was as a senior medical advisor in a "silver commander" role that I worked for the first part of the pandemic (see para 1.5).

Working with the Chief Medical Officer Directorate (CMOD)

1.5 In February 2020 I initially offered my support to the then Chief Medical Officer (CMO), Dr Catherine Calderwood, via the then Deputy Chief Medical Officer (DCMO), Professor Sir Gregor Smith, as one of the senior medical advisors in Scottish Government to help with matters relating to the COVID-19 response. My support was initially provided as part of the Medical Advisory Group (see paragraph 2.2) made up of the doctors working in Scottish Government at that time to support situational awareness and to provide clinical support to the DCMO. My other actions focussed on

engagement with my Emergency Medicine and Acute Medicine colleagues across Scotland, to understand the challenges they were facing during the preparations and early part of the pandemic.

1.6 In March 2020, Dr Catherine Calderwood appointed me as one of two "silver commanders". The other silver commander was Professor Michael Gillies. My job in this role was to strengthen the links between the development and operationalisation of policies relating to the response to COVID-19. In addition to this, I joined an internal CMOD advisory group of senior clinical advisers. This group met very regularly and sometimes every morning at the height of the pandemic. The group met virtually and not in person. Our purpose was to create situational awareness and contribute to solving issues and problems. I have not retained minutes, papers or notes with regards to these meetings.

1.7 During my time in this role, I engaged with clinical groups including the Medical Royal Colleges, Medical Directors and other healthcare directors, and supported the development of clinical pathways for emergency department attendees and NHS24 patients. I took part in a number of other groups as detailed in the table below, which helped provide clinical advice to policy teams on behalf of the CMO or supported specific workstreams directed at delivering guidance to policy or the public. I did not retain minutes, paper or notes regarding any of the meetings below.

Figure 1: Table of groups attended by Dr J Harden

Name of the group	**Role**	**UK or Scotland group?**	**Organiser**
Medical Advisory Group (MAG)*	Member	Scotland	CMOD
CMOD Senior Clinical Advisors Group	Member	Scotland	CMOD
Clinical Cell*	Member	Scotland	CMOD
NHS Louisa Jordan Governance Group	Member	Scotland	CNOD
Nosocomial Review Group*	Member	Scotland	CNOD
UK Clinical Panel for Shielded Patients	Member	UK wide	UKG
Professional Advisory Group*	Co-chair	Scotland	CMOD
Emergency Clinical leads Network	Chair	Scotland	Myself

Clinical Leads Advisory Group for Shielding (CLAGS) *	Chair	Scotland	Healthcare Quality and Improvement Directorate
QCOVID Delivery Group*	Member	Scotland	Population Health Directorate
Chief Executives COVID-19 Board Meetings	Member	Scotland	Office of the Chief Executive of the NHS
Event Industry working group	Invited Member	Scotland	Visit Scotland
Events Planning and Organisation Group with Edinburgh Council and Stakeholders	Invited Member	Scotland	Edinburgh City Council
Elite Sport Clinical Advisory Group	Member	Scotland	Population Health Directorate
Aviation Working Group Contact Tracing Executive Delivery Group	Member	Scotland	Transport Directorate
Short Life Working Group Long-term Effects of Covid-19	Member	Scotland	Healthcare Quality and Improvement Directorate
Mobilisation Recovery Group*	Member	Scotland	Directorate of Performance and Delivery
COP26 COVID Steering Group	Member	UK wide	Foreign and Commonwealth Development Office and Cabinet Office, UKG
COP26 Silver Command Group	Member	UK wide	Foreign and Commonwealth Development Office and Cabinet Office, UKG

* Papers relating to the group have already been provided to the Inquiry

1.8 My main role during this period was as the lead clinician providing clinical advice on shielding, a role which I continued throughout the remainder of the pandemic. In this role I provided clinical leadership and advice into policy teams developing approaches to support those at most clinical risk from COVID-19. To help me in doing this, I convened the Clinical Leads Advisory Group for Shielding (CLAGS), which was a group of clinicians from around Scotland whose specialities encompassed the conditions included within the Shielding list. I chaired this group which took place once a week virtually and worked closely with the Clinical Cell (chaired by Professor Tom Evans) to ensure the advice provided to policy teams was practical and appropriate. This clinical advice and policy was signed off by the CMO, since communications to the shielding population were sent in his name. The meeting was organised by secretariat support within the Healthcare Planning and Quality Directorate. Papers relating to the meeting have previously been shared with the Inquiry.

Deputy National Clinical Director

1.9 I was appointed as Interim Deputy National Clinical Director in September 2020 before taking up the role substantively from October 2020. This was in response to a request for assistance from the NCD, Professor Jason Leitch, as a consequence of the volume of work resulting from the pandemic. In this role the main function was to compliment and support the actions and activities of the NCD. I supported public information campaigns, media interviews and public and stakeholder engagement. This mainly involved provided advice and support on the translation of Scottish Government guidelines and restrictions into practice. I continued as the lead clinician providing clinical advice on shielding and as the Chair of CLAGS. I also continued to attend the Clinical Cell and Professional Advisory Groups as a member.

1.10 In the role as DNCD, I engaged with the following areas or sectors:

- Hospitality, including hotels, public houses/bars, nightclubs, weddings, and soft play.
- Events, including music and cultural events, conferences and seasonal events, e.g TRNSMT Music Festival, Edinburgh Christmas, Edinburgh Festival and Fringe, the Royal Highland Show, The Royal Edinburgh Military Tattoo and COP26.
- Sport, including the Euros 2020, return to professional and amateur sport.
- Schools and Universities, including travel and accommodation.
- Travel and transport, including airlines and airports, cruises, and managed quarantine.
- Industry, including the oil and gas industry, communications providers and pharmaceutical companies.

1.11 In addition, I also provided support to the Joint Committee on Intercollegiate Examinations to run surgical examinations for surgeons in training, the restarting of Driving Tests for vital services, and engaging with the Independent Healthcare Providers Network.

1.12 Furthermore, I supported the early work by Scottish Government in gaining a better understanding of Long-Covid and in the development of policies to deliver care for individuals experiencing Long-Covid. This has continued beyond the timeframe of this request.

1.13 In all of the above areas, my role was to communicate decisions on guidance and restrictions, to the public and stakeholders, explaining the clinical rationale for them and translating them into practice for the particular area being discussed. I was involved in providing clinical advice to the various groups or collating advice from other clinicians and communicating that to policy colleagues and other clinicians. I was not involved in decision making; these were made by Ministers, Cabinet Secretaries or the First Minister.

2. Initial understanding and response to Covid-19 (January 2020 to March 2022)

Initial understanding and readiness

2.1 I initially became aware of Covid-19 via broadcast, print and social media in January 2020. There were minimal internal discussions within Scottish Government of which I was a part of. Where these discussions did occur, they were on an informal basis between work colleagues in passing but there are no specific meetings I can recall. As the spread of the pandemic was highlighted more, I became aware that there was a recognition of the need for wider engagement of the clinicians within Scottish Government to support the development of plans.

2.2 As stated earlier, in February 2020, I offered my support to the then Chief Medical Officer and joined the Medical Advisory Group as a member. This group later became the Professional Advisory Group and met on a weekly basis. I co-chaired this group whilst a "silver commander" for CMO. This group provided wide ranging clinical advice which was considered by the CMO in his contribution to Covid-19 policy decisions and ministerial advice. I also joined the Clinical Cell (see para 1.8) which provided clinical scientific input to CMO.

2.3 In addition, I also convened the Emergency Medicine Clinical Leads Network to better understand the situation and needs from the frontline of acute care. This met weekly via teleconference and never in person. It lasted for the first 3 months of the pandemic. There were no minutes kept as it was informal and there was no formal agenda. I relayed the gathered information to CMO through the regular meetings with other senior clinical advisors as noted previously.

2.4 During this period, I led on the development of Hospital Admission Criteria, engaged with the Army to explore logistical approaches to the pandemic, and also joined

webinars with colleagues from Italy and Wuhan to learn of their experiences of managing Covid-19.

2.5 On taking up the role as a "silver commander", I received an outline of the current understanding of Covid-19, based on the information available at the time from CMO/DCMO. This included information on the known transmission routes, symptoms, infectiousness, and mitigations that had been used elsewhere in the world. It also included the mortality stats from other countries and the mobilisation needs they had had to meet to manage their outbreaks. Information was also shared as to the areas we needed to understand more about, and to work on, to support the NHS and the health of the population.

2.6 I had no involvement in the Nike conference held in Edinburgh on 26-27 February 2020 or the Scotland vs France rugby match held at Murrayfield on 9 March 2020. I believe Dr Calderwood as CMO or Professor Sir Gregor Smith as DCMO were involved in these in conjunction with colleagues from Public Health Scotland.

2.7 Reflecting on this initial period and in my personal opinion, I felt the respective governments were appreciative of the seriousness of the potential threat from the pandemic and made significant preparatory progress. Certainly, within Scottish Government, discussions were underway at official and clinical advisor level before my involvement, with good engagement with politicians. With regards to the wider United Kingdom Government (UKG) approach, I am unable to comment due to my lack of involvement before February and I had no engagement with UKG colleagues until later in the pandemic. Overall, and with the benefit of hindsight, I believe outward actions to support the population could have been started earlier. However, the decisions made during that time were the right ones based on the information available.

Initial Strategy and Decision making

2.8 With regards to the initial strategy, I was not involved in any discussions of the approach being taken and was not involved in discussions on the concept of "Herd Immunity".

2.9 Within the period January to March 2020, the UKG and SG were aligned, as far as my involvement and awareness, in the broad principles behind the approaches to the pandemic, such as lockdowns and shielding. Where, for logistical reasons, divergence

from the rest of the UK was required, I feel appropriate actions were taken by SG in respect of these. I do not feel from my perspective, that SG should have made more or less decisions on their own in the early stages of the pandemic. I believe the decisions taken at the time were right, based on the information available. Nor do I think SG were held back by decisions made by UKG during the early stages of the pandemic.

2.10 During this period, I did not provide any direct advice to the First Minister or other Ministers, and I was not directly involved in any decision making. I was more involved in discussions at the Clinical Cell which were initially around the mitigations within healthcare settings and the potential need for worst case scenario planning. In addition, the need for admission criteria for hospitals was explored, and aimed to ensure those patients most needing care were prioritised and bed capacity was preserved to provide care where/when needed. I brought the learning from the Wuhan and Italian calls into this. Discussions at the Medical Advisory Group were similar. I felt this was an appropriate position to take given our understanding of the pandemic at the time.

2.11 In regard to my position and if it changed, as the pandemic progressed my position remained that the planning deemed necessary was still appropriate. The learning from Wuhan and Italy which I had, supported my feelings that the more we could do to protect our critical care and hospital capacity, the more availability there would be for those needing it. The overwhelming of the NHS would have been catastrophic, and we would be in a worse position now if that had happened more than it did. I continue to hold this position and feel these actions and approach were appropriate.

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

3.1 As stated previously, I was not involved in any discussions involving why SG adopted lockdowns in March 2020. The areas of my involvement have been detailed above. My first knowledge of the lockdown was when I watched the live news of the Prime Ministers announcement to the UK about it. At the time, I felt that the need for this was justified given my knowledge of the experiences in Wuhan and Italy from my engagement with them. Looking back now, I feel that such a drastic approach should have been introduced more progressively than the hard stop we experienced. This is based purely on my current, fuller understanding of the disease and how it spreads and the effects it has. I feel we could have introduced some of the measures to mitigate

Covid-19's introduction to the UK sooner with tighter border controls, and we could have implemented testing strategies at an earlier stage. This would have of course, been dependent upon having these available at sufficient levels earlier too. Likewise, the second lockdown in January could have been introduced earlier.

3.2 In supporting the use of NPIs my main role was to provide engagement with stakeholders, including local authorities. This involved the translation of guidance into practice and in answering questions for clarification on the clinical rationale as to why specific mitigations or restrictions were being implemented. This applied for national lockdowns, local and regional restrictions, working from home, reduction of person to person contact/social distancing, self-isolation requirements, the closure of schools and education settings, the use of face coverings, and the use of border controls. In addition to this role, I also was involved, in my role as chair of CLAGS and as a member of the Clinical Cell and the Nosocomial Review Groups, in analysing data and supporting decisions on the reduction of person to person contact/social distancing and on the use of face coverings in public life, in healthcare settings and with regards the shielding population. I also provided support to Ministers in discussions with local authorities, again to provide translation of guidance into practice and in answering questions for clarification on the clinical rationale behind the mitigations or restrictions. I would also be able to explain the relevant epidemiology within the local authority's area. This same role was also undertaken in supporting Ministers engagement with wider stakeholder groups.

3.3 Through all of my roles within the Clinical Cell, the Professional Advisory Group, the Nosocomial Review Group and CLAGS, our focus was predominantly on the health and social implications of the use of NPIs. The economic considerations were not a major part of the area where I was involved directly, however this was considered as part of the wider approach called "The Four Harms Approach", which ensured the full implications of actions to mitigate the pandemic were included. More specifically, the duration and extent of the use of NPIs was a frequent question raised during discussions with stakeholders. I was involved in discussions about these matters within the above groups as we tried to ensure the need for the NPIs was only for as long as was necessary. The main areas where I was closely involved in these discussions was within the CLAGS with regards shielding patients, and within the Sport, Events, Travel, and Hospitality sectors.

3.4 Looking more specifically at the population at highest risk and those most vulnerable

within society, SG took particular care to ensure the impacts on these groups was considered. From a general perspective, the Covid Four Harms Approach ensured this was included in all advice being presented to ministers. Furthermore, there was a policy unit set up to look at the specific needs of the Shielding/Highest Clinical Risk groups. This policy team commissioned surveys of the Highest Clinical Risk population to garner feedback from them on the impacts of the restrictions, the guidance and the implementation of these. I was closely involved in reviewing the findings from these surveys and with the discussions at CLAGS to look to how these could be adapted to minimise any consequences. In addition, throughout the pandemic equality impact assessments were undertaken to ensure all advice and subject matter took equalities into consideration [JLH/001 – INQ000249279].

3.5 On reflection, I feel the approach to NPIs was well done by SG and that the guidance and communication of it worked very well. Regular updates from the First Minister, other ministers and clinicians such as the NCD, Professor Jason Leitch, aided the understanding of the public and stakeholders of the benefits and need for them. Within the areas I was involved with, the information sharing and the adequacy of it, was good and worked well. Also, the teamworking was excellent within SG, with close working between clinicians and policy teams. This was also evident in my interactions with UKG colleagues in my work with the UK Clinical Panel for Shielded Patients, where clinical and policy discussions worked well to support an aligned approach for the most part.

4. Divergence

4.1 Within my field of work, the main area where divergence of approaches occurred was with the approach to the Highest Clinical Risk patients (Shielding List/Clinically Most Vulnerable Group in other parts of the UK). This was not just in the nomenclature used but also in the advice given to specific groups. For example, when evidence supported a change in shielding advice for children, children in Scotland were advised they no longer needed to shield before the rest of the UK, due to the differences in timings of school holidays, so that they could return to school for the start of the new term. Other areas of divergence were in the use of the QCOVID Risk Stratification Tool which was not implemented in Scotland. Additionally, the timings of the changes in advice to those at Highest Clinical Risk were different in Scotland in order to align with the general restrictions in place for the wider population. This divergence began as far as I was aware, from June 2020.

4.2 I am supportive of the decisions taken to divert from the other 3 nations, within the

contexts in which these decisions were taken. I think they were the right decisions for the population within Scotland and were based on local needs, either from a pandemic or from a wellbeing perspective of the particular section of the population. The wider general approach of the Scottish Government is one of empowerment and autonomy of the population to make decisions for themselves, and the approaches used with the Highest Clinical Risk Group were in keeping with this, rather than over paternalistic.

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

5.1 In general, I contributed to the discussions on the impacts of NPIs within the Professional Advisory Group, the Clinical Cell, the Nosocomial Review Group and with the CLAGS. More widely I helped with the translation and explanation of the clinical rationale behind the guidance and restrictions being applied in discussions with stakeholders.

5.2 More specifically, in my role as chair of CLAGS, I encouraged the clinician group to identify the most clinically appropriate options that would support the best outcomes in protecting those at Highest Clinical Risk. Subsequently, with the arrival of vaccines, the discussions looked at what impact these had on the need for NPIs in this population. The outcomes of these discussions was incorporated into policy and relayed to the CMO for signoff of the clinical advice and suggested approaches, before final decisions were made by ministers.

5.3 Overall, the groups in which I was involved, and the cooperation of clinical colleagues worked well to provide clinical advice into policy. The information available was adequate and where required, sufficient additional information was forthcoming. I feel we could have possibly used the QCOVID Risk Stratification Tool sooner, had there been better cooperation between UKG and the devolved nations with regards the learning from England's experiences of implementing it. The use of the QCOVID Risk Stratification Tool was initially undertaken by UKG in England, but the other nations were not consulted or included in any of the planning for its implementation. We were "told" they were using it and what numbers they would need to add to their shielding list afterwards. Furthermore, issues with data extraction from healthcare records for use in the tool which were encountered by the team in England and were not shared. These lessons could, in my opinion, have helped the other nations to better understand the challenges of implementation and a more collaborative approach may have benefitted all. However, I do not think this made a significant material difference to the

eventual outcome for the Highest Clinical Risk population. Otherwise, I feel the modelling available to the wider clinical groups and individuals was excellent and very helpful in my translation and communication role.

6. My role in Covid-19 public health communications

6.1 I complemented and supported the NCD, in delivering both public facing and stakeholder facing communications on the public health guidance and restrictions in place during the pandemic. The main areas of focus for me were within the areas as outlined above (see para 1.11). In engaging with these areas, I provided advice on the clinical rationale behind the restrictions and guidance at the time, and translation of that guidance into practice for the particular stakeholders. I also undertook a small number of broadcast media interviews to do the same and supported public health messaging campaigns.

6.2 I found that the public and stakeholders were generally appreciative of the input I provided. Indeed, some requested separate meetings to allow for more detailed discussion and understanding of specific areas, particular to their own situation, to be explored. There was a general recognition of our willingness to try to help them and support them to comply with the guidance. My willingness to physically visit sites or venues, to understand issues or logistical matters, aided significantly in this. Examples of this are my visiting a nightclub to understand the challenges of different venues and the work being undertaken; visits to soft-play centres to again see and understand the challenges and site visits for events and conferences to support better understanding and demonstrate what the guidance meant in specific circumstances.

6.3 The impact of breaches in guidance and regulations in both Scotland and England, had a significantly negative impact on the ability to communicate with the public, as they immediately presumed that if one had broken the rules, then all of us were doing so. This damaged the trust needed to ensure the highest levels of compliance were achieved for the regulations and guidance to have the maximum effect. I think that because the bulk of the public facing advice in Scotland came from SG and not from UKG, the impact of UKG breaches was less than it would have been had all advice been coming from UKG.

7. My role in public health and coronavirus legislation and regulations

7.1 I had no role in providing advice to Ministers or in decision making with regards the

Public Health and Covid Legislation including the Covid Act 2020 and the Covid (Scotland) Act 2020. As stated previously, I helped communicate the guidance to stakeholders and the public and also in the translation into practice and clarification of the clinical rationale of this guidance.

7.2 Within my scope of work, I am not aware of any issues with the legislation, and I feel it was proportionate and mindful of the need to protect the population of Scotland. I am unable to comment on any improvements that could or should have been made to it.

8. Key challenges and lessons learned

8.1 During the time period specified, I did not provide any evidence to parliament or any of its committees. I have however supported the lessons learned work by the Highest Clinical Risk team to ensure our experiences and ways of working have been captured and the benefits and pitfalls recognised [JLH/002 – INQ000249280].

Personal lessons learned

8.2 From a personal perspective, I have learned a huge amount about the advantages of early engagement with stakeholders, and of taking the time to listen and understand the issues from their perspective. As a practicing clinician, this is something I do on a daily basis whilst consulting with patients, and it has been an invaluable skill to be able to use this in this way. I would wholeheartedly recommend collaboration with stakeholders as early as possible in the event of future crises or pandemics, as doing so is mutually beneficial for all.

9. Information Communications and Documents

9.1 During the pandemic, I did not use WhatsApp or any other messaging services, for communications with Ministers or to discuss policy approaches to Covid-19. WhatsApp was only used for logistical discussions and awareness raising purposes between officials and clinical advisors. No Government business was discussed nor was any advice given using it. Neither were any decisions made or reviewed on this platform. None of the content was saved. Once any such message was read, it was no longer needed and therefore deleted manually or by an auto-delete function. No other messaging services were used for these purposes either.

9.2 I hold physical notebooks containing personal notes during the period relating to this statement. These were to assist me in meetings and to aid in performing my role. I am happy to make these available to the UK Covid Inquiry for inspection if required.

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: 03/11/2023