Witness Name: Donna Bell
Statement No.: 1
Exhibits: DMB
Dated: 13 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DONNA BELL CBE

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

1. I am Donna Bell, currently co-Director of Social Care and National Care Service Development Directorate within the Directorate General of Health and Social Care ("DGHSC") (overseen by the Director General of Health and Social Care) at the Scottish Government ("SG"). I have been a civil servant in SG since December 2002. I held six posts in government to January 2020. Those include team leader posts (Education Finance and Youth Justice); unit head posts (Head of Youth Justice and Head of Early Years); deputy director posts (Strategy, Performance and Raising Attainment in Learning and Police Division in Community Safety Directorate) and; Director post (Mental Health).

2. I was Director of Mental Health in January 2020. I was appointed co-Director of Covid Health Response (with Richard Foggo) on 16 March 2020. I was appointed Director of Mental Health and Social Care on 1 June 2020. This role was split in December 2021 and I became Director of Social Care and National Care Service Development and remain in that role now, since October 2022, along with a co-Director, Angie Wood. Hugh McAloon took on the role of interim Director of Mental Health in December 2021.

3. I have an MA (Hons) degree from the University of Glasgow (1994) and a Masters of Business Administration (MBA) from the University of Edinburgh (2001).

4. 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, the information governance teams in DGHSC and in the Social Care and National Care Service Development Directorate. They have provided factual information to support the preparation of this statement.

5. 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.

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

Role in decision making

7. Throughout the period under consideration by the Inquiry I acted in line with the well understood role of a UK civil servant (employed by the Scottish Government) and in line with the Civil Service Code. My role was primarily to support Scottish Ministers to: make decisions on the basis of informed advice, in line with their Executive function, supported by the relevant legislation; engage with the Scottish parliament in their role as legislators and; engage with a wide range of stakeholders.

8. I was authorised to make decisions on:

    - The content and presentation of advice, the risks and issues to be considered and the recommendations and conclusions.
    - The deployment of staff resources and spending in line with my delegated budgetary authority.
    - The nature, frequency and content of engagement with stakeholders and partners at official level.

9. These delegated decisions were supported by explicit Ministerial authority or authority from my line manager. My line manager throughout the period defined was the Director

General for Health and Social Care, and Chief Executive of NHS Scotland. Over this period that position has been held, in turn, by Malcolm Wright, Elinor Mitchell, and Caroline Lamb.

10. It is important to say that the time period in question was extremely challenging and I can safely say the most difficult set of circumstances I have experienced in my career. Working days were routinely 12-16 hours over 7 days, particularly in the early phase of the pandemic. The pace of change, the level of information to be absorbed as our knowledge improved, and the responsibilities associated with the role were significant. Ministerial advice was being provided rapidly on multiple, complex subjects with an emerging evidence base. At all times I was clear that the pandemic presented a significant risk to the lives of our population and I took that responsibility extremely seriously.

11. I complied all times with relevant Covid regulations and guidance in force. I worked from home during the pandemic. I also found that Scottish Ministers understood and undertook their responsibilities at all times in line with the Ministerial Code and in line with relevant Covid regulations and guidance. Almost all meetings were by phone or by other virtual means, but on the very rare occasion that they were in person meetings (in line with regulations) face coverings were worn, social distancing was observed and all necessary precautions were in place. I therefore cannot say any more about any alleged breaches of rules and standards by Ministers, officials or advisers.

12. I also complied at all times with SG's policy on the use of informal communications including WhatsApp. No decision that I am aware of, and none that I was responsible for was made via WhatsApp and all decisions and the rationale behind them were properly recorded using our corporate document management system eRDM, to ensure the official record was complete. Scottish Government guidance, including Scottish Government Records Management Policy, makes clear that information and records should be retained only as long as they are required to support Scottish Government in its business requirements and legal obligations. I followed this guidance in the management of all records.

13. WhatsApp, and other informal means, were sometimes used to share information on logistics e.g. timing of meetings, changes to arrangements for meetings whether by phone or on MS Teams and getting in touch with people when they were offline on SG accounts to arrange meetings. On occasion they were also used to check on the most up to date position on guidance or information on specific issues when colleagues were offline.

14. We also used WhatsApp for pastoral reasons - to check in with colleagues on their wellbeing and to ensure that some sense of morale was maintained. Significant pressure was being placed on multiple colleagues and teams and it was extremely important to me in my role as a line manager and SG Director to ensure that I was providing support for colleagues.

15. I was part of a number of WhatsApp group chats e.g. one for HSC Directors but these have the automatic deletion function activated in line with policy, so I no longer have access to these messages. I also exchanged WhatsApp messages with colleagues on an individual basis from time to time on my personal phone, but given the pastoral and personal nature of these exchanges these were also auto-deleted for storage purposes.

Background and overview of roles held

16. It may be helpful to the Inquiry to set out some of the background, the interaction with colleagues and our working practices within DGHSC before I provide information on my personal actions.

17. As a civil servant and an SG Director, I have a corporate responsibility to ensure that the SG can carry out necessary functions and deliver for the people of Scotland. This manifests primarily in ensuring that there are sufficient resources, both staff and financial to allow us to carry out these necessary functions. A significant portion of my time during the pandemic was spent securing the necessary staff, redeploying them to areas of priority throughout and ensuring that that all areas of priority work were being dealt with in a timely and effective manner.

18. We essentially have three areas of expertise in DGHSC. Broadly, but not exclusively, these cover:

- Policy - setting of overall aims and outcomes; identification of strategic risks; equalities considerations; impact assessment; strategic choices of how to deliver and through whom e.g.NHS or local government or third sector; budgetary considerations; parliamentary and UK relations.

- Clinical – clinical, medical, scientific and public health expertise; academic and professional knowledge; links with Health Protection Scotland/Public Health Scotland; knowledge of and links to domestic and international sources of evidence and intelligence such as the Scientific Advisory Group on Emergencies (SAGE) and other UK and global networks; understanding of the professions and their knowledge base.

- Delivery – deep understanding of system delivery, services, workforce matters, technology; networks and connections throughout the system to secure rapid change; deep understanding of interdependencies between services across the system; understanding of system, workforce, technological and other vulnerabilities and risks, and appropriate mitigations.

19. These often overlap and colleagues may have experience and expertise in all, or some of these. One of the key features of how DGHSC works is to bring together these areas of expertise to secure a coherent policy position, clinical approach and delivery mechanism. My skill set is firmly in policy and working with partners to secure delivery. I do not have a clinical background or expertise. This meant close working with the Chief Medical Officer (CMO), Deputy Chief Medical Officers (DCMO), the Chief Nursing Officer (CNO), Deputy Chief Nursing Officers (DCNO), the National Clinical Director (NCD) and delivery colleagues. This is explained in more detail in paragraphs 20-26.

20. A significant part of the three roles I held over the period in question was therefore to secure coherence across those three areas and to ensure that I was presenting

consolidated, clinically sound, coherent and deliverable options to Ministers, supported by colleagues and their subject matter expertise.

21. This was not always straightforward, given the pace that we were working at, legitimate overlap in responsibilities and the interdependencies that exist between the different DGHSC areas. The pace and urgency of the emerging evidence was unprecedented, particularly in the early phase of the pandemic and this meant we had to change the way and the pace at which we worked together and how we provided advice. New clinical and scientific advice and intelligence on the progress of the pandemic was emerging on a daily basis. Pre-pandemic we would, as a matter of course, expect all relevant policy, clinical, scientific and delivery advice to be incorporated into a single comprehensive product i.e. a submission or paper, over time. However the circumstances we found ourselves in meant there was often no time to follow this traditional approach and advice was therefore provided orally or in shorter form written advice, with subsequent follow up to ensure the official record of events was complete.

22. In addition to attending relevant, topic specific meetings and receiving written advice, to ensure that we were appraised of emerging evidence, system intelligence and kept up to speed with likely forthcoming decisions to be made, HSC Directors met 7 days per week over many months. This ensured that we were able, in most cases, to provide coherent advice for Ministers. Despite the pace and rapidly changing environment we worked well together and I am not aware of any substantial disagreement between senior clinicians or across the wider DG in relation to the provision of advice.

23. This collegiate approach can be exemplified in multiple instances throughout the period from March to June 2020 (the period covered by my role with Richard Foggo as Director of Covid Health Response). We provided initial comprehensive advice to Ministers on topics such as shielding, testing, contact tracing, surveillance, outbreak management, data management, HSC resilience and many other topics. Some of this initial advice was written by me, but much of it came from the wider Directorate, with the support of subject matter experts. I will provide further detail on the nature and content of the advice later in this statement.

24. A pattern developed in that, once the initial advice was provided and Ministerial decisions were taken on the options available, a shift to the delivery phase often initiated the set-up of new teams or directorates to ensure effective delivery. These were often cross government or whole HSC system in their reach. Shielding those who were Extremely Clinically Vulnerable is a good example of this. I wrote the initial advice to Ministers, drawing in clinical advice and, working quickly with local government and other partners through civil contingencies mechanisms, secured a likely delivery route for emergency support for those people required to shield, over a 24 hour period [DMB/001 - INQ000249500]. It very quickly became clear that delivering this effort required a dedicated team to consider all policy aspects, including those relating to identification of strategic risks; equalities considerations; impact assessment; further work on delivery roles of partners; budgetary considerations and parliamentary and UK relations. The Shielding team was put in place rapidly to respond. This pattern continued and after initial policy initiation a number of teams, divisions and in some cases Directorates were created to support and oversee delivery. These included, not exclusively Directorates for: Testing Operational Policy, later Test and Protect; Personal Protective Equipment (PPE); Shielding; Outbreak Management and; Vaccinations amongst others.

25. These distinctions were not always clearly articulated (given the pace of the pandemic and legitimate overlap in responsibilities etc.) but good collaboration internally and externally, including with Public Health Scotland and Directors of Public health in particular meant, typically, that that did not interfere with delivering required outcomes. Decisions to stand up new teams were made by Directors General based on discussions with Ministers with a focus on ensuring civil service staffing was not a rate limiting factor in delivering outcomes.

26. Overall, good collaboration and a collegiate approach internally across DGHSC and wider SG and with external partners meant that we were able to deliver the required actions and outcomes.

27. It is fair to say that many lessons were identified from the experience of the pandemic. With a range of colleagues I participated in the completion of an initial lessons

identified exercise for the period March - September 2020 [DMB/002 - INQ000147474].

28. I would however offer a few areas worthy of reflection. It is important to note that while there were some teething issues and ongoing debate about how we operated, this did not impact on the overall response or the desired outcomes:

29. **Concurrent risks and threat assessment**- SG has a comprehensive approach to concurrent risk and threat assessments and these are improving on a continuous basis. It may be useful to reflect on the application of these processes to fast-moving and dynamic threats such as the pandemic.

30. **Clarity of roles and responsibilities across SG** – as information emerged, it quickly became clear that a fully cross-government response would be required. There were differing levels of engagement with the response, depending on the understanding of the reach of the pandemic and the magnitude of the emergency.

31. **Clarity of functions**- as outlined above, policy/clinical/delivery functions and roles are reasonably well understood across DGHSC. It took a little longer across government to understand this way of working and the actions that would be required across the different sectors. Clinical, and to some extent, high level policy advice and decisions would likely emanate from DGHSC but implementation rightly needed to sit with other areas of government who were more familiar with their sectors and who held policy responsibility for specific areas.

32. **Medium to long term emergency response** - SG is very well supported for short term emergency situations through the Scottish Government Resilience Room (SGORR) and this usually focusses on short, intense response periods e.g weather events; significant short term matters with civil contingencies impact etc. The approach to addressing a longer term emergency situation adapted during the course of the pandemic with the introduction of the GOLD group and the Four Harms work, but the sustainability of this type of response, in particular over longer periods (in this case years) is an area for further consideration.

33. **Clarity of relationships with delivery partners** – SGORR was a key part of the formal engagement with partners. Crucial wider engagement with local government and other civil contingencies partners also happened through a variety of fora over the period in question. Linked to the points made at paragraph 29 it may be helpful to consider the roles of the partners present.

34. **Workforce planning and deployment** - this merits further consideration both internally within SG and with external partners. Change was required at a previously unimaginable scale. There is useful learning on what worked and what we can improve, and the pace at which change was required.

January to March 2020

35. I became aware of the COVID-19 threat in January 2020. In addition to my role as Director of Mental Health, I was also chair of the DGHSC People and Capability group, charged with consideration of upcoming priority issues on staffing matters and the associated risks.

36. The issue was initially raised with me in that context due to increasing pressure on the Public Health team to address COVID-19 related briefing and support requests. Given the specific nature of the roles required and a preference for staff with knowledge of public health and the operational delivery of public health activity, I made approaches to people who had previously worked in the area. Given the urgent need for support I was able to secure the immediate release of several colleagues to provide this additional support. I remain very grateful to them for their willingness to assist.

37. In early February 2020 it became clear that a larger scale support operation would be necessary to support the COVID-19 response and I was asked by the then DG to consider how we could support that. It was also clear that a whole of government response would likely be required, although at that time the scale and reach of the response was not yet clear. For that reason the initial focus was on supporting Ministers and DG HSC on informed decision making and readiness to respond.

38. Broader SG resilience arrangements were already in place through SGORR and support arrangements for NHS Board resilience were covered by Health Emergency Preparedness, Resilience and Response (EPRR), most specifically focused on the acute sector. It became clearer during the latter part of February that an acute hospital focus would be insufficient and we needed to broaden this to the wider health and social care system.

39. The DG routinely provided updates to SG Executive Team (ET) during January and February supported by HSC colleagues to describe the potential risks, the initial response required across health and social care and the likely staffing requirements to support this. This included the bolstering of Health EPRR and the set-up of a hub arrangement that could operate 24/7 if necessary. My previous experience of emergency situations and resilience and the potential emerging threat suggested that the situation could be volatile and unpredictable and would potentially require intelligence and briefing at short notice at any time of the day or night depending on circumstances. Multiple exchanges took place over the course of February and early March, and I attended ET with the DG on 9 March 2020 to set out the urgent need for more resources to support the Covid response, including additional leadership capacity.

40. The request to ET was for sufficient staff to operate an HSC hub, offering a 6am - 10pm working pattern in the initial stage. This would require up to 100 staff. There was also a need to support Health EPRR to operate over similar time periods. At that time we did not have a clear understanding of the duration of the 'emergency' period. Health EPRR were well set up to support this in the short term but if the situation were to continue for weeks or months they would require further support.

41. There was some resistance to this request for support from other DGs. The COVID threat had not fully materialised during February and was firmly considered as a risk rather than an imminent issue to be addressed. This continued into early March and there was a sense that this could be managed within HSC and was ostensibly a 'health' problem. There were other pressures on the organization, particularly around the imminent EU exit and there was some reluctance to release staff from key areas

affected. DGs and Directors not significantly affected by EU Exit were more open to providing support and this was gratefully received.

42. The appreciation of the seriousness of the threat was mixed across SG. None of us had lived through a pandemic and it was not clear at the outset exactly what the impact would be, given our level of knowledge about the characteristics of Covid-19 and the emerging evidence of impact. In many respects the scenarios and potential impact were difficult to describe. Those closest to the public health advice worked hard to escalate the potential risks, mitigations and actions required, learning from emerging evidence and experience from other countries. In the very early stages, internationally, the main impacts were on health services and on wider resilience. Reasonable Worst Case Scenarios were presented to ET but focused mainly on potential death rates and the impact on the NHS. This understandable lack of clarity and the uncertainty on the potential impacts on wider society, coupled with immediate pressures on EU Exit and other matters, meant that the risks identified rapidly became issues that required immediate action.

43. During the period throughout January to mid- March 2020 I was peripherally involved in the decision making process around public health measures but did not provide any direct advice to Ministers. I therefore cannot comment further on the following subjects:

- The Nike conference on 26/27 February 2020
- The Scotland v France Six Nations Rugby match on 8 March 2020
- The concept of herd immunity
- Alignment with UKG
- The benefits of alignment or otherwise with UKG approach
- Curtailment of SG in approaching Covid -19
- The use of a lockdown or initial strategies.

March to June 2020

44. During February 2020, I had spent more and more time working with colleagues preparing to develop a response to Covid, which was first an outbreak, then a "Public

Health emergency of international concern" (PHEIC) (as declared by World Health Organisation (WHO) on 30 Jan 2020) and then a pandemic (as declared by WHO on 11 March 2020). I also continued to lead the Mental Health Directorate at that time. After the ET meeting on 9 March 2020, in discussion with DG Health and Social Care Malcolm Wright, it was agreed that the extent of the responsibilities likely to be forthcoming to respond to the pandemic were such that resource enhancement was necessary. At that time I offered to partner Richard Foggo (at that point Director of Population Health) in a new role "Director of Covid Health Response" to ensure resilience in Covid Health Response. This Directorate was established on 16 March 2020.

45. The directorate structure was fluid at the start with colleagues working on a proactive and responsive basis, both on issues of the day and planning work to develop new policy and delivery options on a range of topics. Over the course of March we continued to augment the leadership of the team.

46. This role of the Directorate was to provide

- A credible and coherent Covid policy function for DG HSC, that would provide advice to Scottish Ministers, primarily the Cabinet Secretary for Health and Social Care, but also increasingly directly to the First Minister, and in time, in partnership with wider SG colleagues, to other Ministers.
- To establish the DG HSC "group hub". Since January 2020, as part of the health protection and health resilience "stand up", there was a "hub" arrangement in place.

Policy Function

47. During March it became ever clearer that the Pandemic would have a wide reaching impact across Scottish society, and for that reason became a wider, whole of Government endeavour. So while we engaged regularly and intensively with SG colleagues our focus began to shift to health and social care policy.

48. Richard Foggo and I oversaw the production of advice on a wide range of subject matter: testing, contact tracing, surveillance, shielding, very early preparations for any

future vaccination programme, elements of overall Non-Pharmaceutical Interventions (NPIs) and exit strategy. This function was led at Deputy Director (DD) level by Derek Grieve, Daniel Kleinberg and John Nicholson. It was also the case that given the pressures on time and the very high volume of incoming work it was often the case that we 'tag-teamed' across the range of activity we had to cover. One of us would start a piece of work and others would finish it, or vice versa. At that time we were all working long hours and over seven days to deal with the large volume of issues.

49. To provide informed advice to Ministers on these matters we sought a wide range of clinical advice from CMO, DCMO, CNO, DCNO and NCD and other colleagues, and the wider HSC sector including Public Health Scotland and Directors of Public Health, amongst others, and the Scottish Covid-19 Advisory Group on occasion.

50. During this period I also engaged with UKG and the Welsh and Northern Irish offices on the early plans for the Joint Biosecurity Committee (JBC). My engagement was primarily on the early governance arrangements for the JBC rather than the content of their work or their outputs. Initial discussions suggested governance structures that may have been difficult for Devolved Administrations (DAs) to work with but this was later resolved. [DMB/003 - INQ000249499]. The discussions with UKG on these matters were constructive and they shared the information and rationale behind their suggestions and decision making at each stage. Relationships between SG and the other DAs were positive and constructive.

51. For the reasons outlined above, advice produced may have been submitted in the name of others; very little of the advice referred to above is in my name personally. I attach the key pieces of advice in my name (or jointly) contained in initial Evidence retrieval, Exhibits [DMB/004 - INQ000222879]; [DMB/005 - INQ000249503]; [DMB/005a - INQ000249504], [DMB/006 - INQ000249497], [DMB/006a – INQ000249498] and; [DMB/007 - INQ000222888].

52. By early April 2020, various functions associated with the initial advice provided and previously led by me (and Richard) had already been passed to new teams as referenced earlier. Richard and I were referring explicitly in our advice to DG HSC and others, of the need to work in partnership with, for example, Dominic Munro as lead SG Director on NPIs and exit strategy, Annabel Turpie on testing, and Michael

Chalmers on shielding. In relation to the first point above, there were in addition

emerging Covid functions in other DG "families" (e.g., economy, communities etc.). I contributed to and brought together advice on NPIs, including testing, over this period although as per the previous description this was a collegiate effort and may not have been submitted to Ministers in my name.

Group Hub

53. Over the course of late February/early March, with significant effort, we secured the necessary staff to set up the hub and to bolster our support arrangements across HSC to ensure that we would be ready to respond if the situation deteriorated. We agreed a daily and weekly set of products required and the frequency with which they were to be provided, for the provision of information and intelligence.

54. This grew in size and responsibility over the period to the point when at the outset of the new Directorate in March we had assigned two Deputy Directors to oversee its creation and management (Lesley Sheppard and Willie Cowan). The principal functions of the hub were to, first, coordinate Ministerial situation reports ("sitreps") (within DG HSC and contributing to SG sitreps), and, second, to handle Ministerial briefing and correspondence on Covid.

55. On March 17 we launched the Hub, and almost immediately after that the first restrictions were announced. Having the arrangements in place to support intelligence gathering, briefing and support for the resilience effort was hugely helpful at that stage. The Hub produced a daily sit-rep on all matters relating to HSC in Scotland for the duration of the pandemic emergency period. These sit-reps have been supplied to the Inquiry separately. Having the hub in place meant that we were immediately able to provide a coordinated source of information and briefing across the DG for Ministers and senior leaders rapidly.

56. The sit-reps were widely used for resilience purposes and to support and inform advice and decision making at SGORR (Official) and SGORR (Ministerial) meetings. During March-May, these were taking place at a minimum weekly, with a range of delivery partners as referenced in the SG corporate statement. I attended multiple SGORR

(Official) and (Ministerial) meetings over this period, updating on information and intelligence on occasion.

57. In addition to SGORR meetings, a senior level working group underpinned some of this resilience focused work. The Concurrent Risk Oversight Group (CROG), chaired by Mark Williams, Assistant Chief Constable, Police Scotland, met at a minimum weekly and considered risk and resilience issues at a strategic level, as referenced in the SG Corporate statement. This group routinely included almost all Category 1 civil contingencies responders and other relevant parties. As the name suggests, while this group had a specific and intentional focus on the COVID-19 threat, it also considered contingent risk such as poor weather conditions or other matters that may have an impact on our collective resilience. I attended this group regularly, primarily to provide updates on current information and intelligence, but on occasion on issues such as testing, vaccinations and other matters. Other Scottish Government colleagues also attended e.g. Michael Chalmers on Shielding, Annabel Turpie on Testing etc.

58. This cross sectoral working group enabled sharing of information to establish shared situational awareness, feedback on risk and resilience issues and allowed for escalation to take place where significant issues were identified or where contingent risk was clear. This group worked well, particularly in the early stages of the pandemic, but as the pandemic progressed was difficult to sustain in that form. The arrangements evolved and this was replaced over time by the overarching GOLD group and the Four Harms Group which were led by colleagues later in the pandemic. Both of these groups are referenced and explained in more detail in the SG Corporate Statement.

59. The two principal functions of the Directorate of Covid Health Response were delivered through a matrix management structure that operated effectively "24/7 365" shift patterns using both on duty and on call arrangements. These structures were fluid and responsive, with advice being produced collectively within the team and with colleagues as described at paragraphs 16-23 and work allocated on a day by day basis. We were being supported by military liaison officers at this point, in particular on the Group Hub function to ensure effective information flows.

60. This was undoubtedly the most challenging period in the whole of the pandemic. We were working at home (after the 23 March stay at home order), with limited technology,

with on duty shifts covering 6am to 10pm (sometimes earlier, often later). A key focus for my time during this period was line management support. A number of colleagues experienced real difficulty and "burned- out". The surge capacity of around 100 staff, consisting of volunteers from around the SG was extremely welcome and the induction and management of these staff was a significant focus for Richard Foggo and me. This was sufficient to count as a function in its own right.

June 2020- December 2021

Roles and arrangements

61. In May 2020, Richard Foggo and I undertook a review of the Directorate of Covid Health Response. This was intended to bring more stability to our structures as roles and functions were clarified. This led us to end the matrix model and re-introduce a more "traditional" Divisional structure. In June 2020 the Directorate of Covid Public Health was created. It was decided (by DG HSC Elinor Mitchell) that Richard Foggo would lead that Directorate on his own.

62. From June 2020 until December 2021 I therefore took on the role of Director of Mental Health and Social Care. This was a return to my original role as Director of Mental Health and I agreed to take on additional responsibility for Adult Social Care. Children's Social care continued to be led by colleagues in SG Children and Families Directorate.

63. This stemmed from a number of developments in the DG, including the resignation of the DG for health reasons and the temporary promotion of the Director of Community Care, Elinor Mitchell, to the DG role. At that time the Director of Community Care role was split into Director of Primary Care and Director of Social Care. The Director of Primary Care role was undertaken by Aidan Grisewood and another colleague, Alison Taylor, had undertaken the adult social care role on temporary promotion, but she no longer wished to continue. For a number of reasons, it was not possible to secure another director candidate to fill the role on an immediate basis. In many places, the organisation was under significant staff pressure to meet the demands placed upon it and Adult Social Care was, at that time, perceived to be a very difficult brief.

64. At that time, the social care directorate was entirely focused on pandemic response, with particular focus on care home resilience and wider support for the sector. In addition to establishing risks, issues and required actions during my initial period in post, I also undertook a review of the resourcing and structures required to stabilize our response to supporting adult social care given the likely longer term nature of the exercise.

65. From October 2020 I restructured the directorate to ensure that we were stable and more resilient. This led to the recruitment of new staff, in particular deputy directors to support the response effort. This allowed more focused attention to issues such as outbreak management, support for care settings and services, testing, sustainability and clearer communications and points of contact. Given the progress of the pandemic at that time we also began to consider recovery and remobilisation more effectively.

66. As more issues emerged over the course of late 2020/ early 2021, I undertook further work to assess the resource requirements across the directorate and with the conclusion of an SG deputy director board revisited the arrangements again, bringing further focus to the directorate on workforce issues, the integration of health and social care, regulation and inspection and deeper work on remobilisation, as well as ongoing work on pandemic response.

December 2021 - April 2022

67. In December 2021, given the Omicron outbreak, the increasing workload for the development of social care reform activity and the development of the National Care Service, the directorate was split, with Mental Health being led by Hugh McAloon and I retained my role as Director of Social Care and took on additional duties on the development of the National Care Service.

Background and context

68. On my arrival in the newly formed directorate in June 2020, I was familiar with the Mental Health structures, processes and stakeholder engagement arrangements and the Deputy Directors, Hugh McAloon and Angela Davidson had stepped up admirably

to ensure that Mental Health concerns and risks had been well managed in the period while I had been working in the Covid Public Health role.

69. I had been involved in social care in my previous role, through specific work on testing in care homes and peripherally through engagement in HSC meetings and from a broader resilience perspective. I had to very quickly understand the specific and detailed risks and issues, the networks for communication and the steps required to continue to support social care through the pandemic.

70. It is important to note that, as outlined in the SG Corporate statement, Scottish Government does not have statutory responsibilities or accountability for the provision, commissioning or delivery of social care support and services. Statutory responsibilities for these matters are held by local government. This responsibility is in some cases delegated to Integration Joint Boards, but local government remain legally accountable.

71. Given the risks to care home residents, significant work had already been done to engage with partners responsible for delivery. As set out in the Module 2/2a Corporate response, at that time this included daily meetings with Integration Joint Board Chief Officers to assess risk and share information, Care Home Rapid Action Group (CHRAG) meetings twice weekly and on an ad-hoc basis when required. Close engagement was also required, often through SG clinicians with Public Health Scotland and their health protection teams. The CHRAG was later replaced with the Pandemic Response in Adult Social Care Group (PRASCG), chaired jointly with the Convention of Scottish Local Authorities (CoSLA), which met twice weekly and later weekly, to ensure we had appropriate focus on the wider social care sector in addition to continuing support for Care Homes. This was later replaced by the Adult Social Care Gold Group which was, again jointly, chaired by CoSLA and operated in conjunction with similar arrangements for the NHS. The Terms of Reference for these groups and their membership was set out in the corporate response to Module 2/2a of this Inquiry.

72. The impact of the pandemic on adult social care was enormous and difficult to understate. Significant volumes of guidance to care homes had already been issued by June on such topics as outbreak management, Visiting, Infection Prevention and Control, PPE, testing, NPIs and other matters. Guidance had also been provided on

new admissions to care homes either from hospital or from the community. This was coupled with advice and guidance on discharge from hospital to care homes. Significant activity had already taken place to ensure the breadth of the sector had access to PPE and Outbreak Management support. I was not involved in providing advice any of these matters, with the exception of early advice on nosocomial testing as stated earlier and as outlined in [DMB/006 - INQ000249497] and [DMB/007 - INQ000222888].

73. Significant further guidance and support was require to ensure the sector was supported on a continuous basis. As described earlier, in a similar way to my previous role in Covid Public Health much of this advice was developed jointly with clinical colleagues and colleagues with delivery experience, including CMO, DCMO, CNO and DCNO. It was often authored by multiple colleagues, at a rapid pace and with information emerging on a daily basis. Once again a major part of my role was to ensure that policy, clinical advice and our delivery mechanisms were coherent and actionable. Specific letters in my name, but developed collaboratively are at exhibits [DMB/008 - INQ000147360] and [DMB/009 - INQ000222889].

74. I am cognisant that the provision of significant volumes of guidance, immediate changes to practice and the technical nature of the information must have proven difficult for colleagues across the sector to digest and implement. Wherever possible guidance changes were kept to a minimum and as much notice as possible was given. However, given the need for immediacy in most cases we often required same or next day implementation.

75. On rare occasions there was some minor divergence from a 4 nations approach on the policy and delivery approach to the pandemic response to adult social care. While the aims were similar, the timing and approach was on occasion differentiated. This was unusual and we worked closely with colleagues across the 4 nations to keep our actions coordinated. Where divergence occurred, this was based on the clinical and scientific evidence at the time and Ministerial risk appetite. It is important to note that my role in this was to provide advice rather than make specific decisions. Decisions rested with Ministers. Minimal divergence occurred on some occasions on issues such as Care Home visiting and staff and service user testing, usually on timing rather than

aim. On occasion there appeared to be slight divergence due to mobilisation times across the 4 nations.

76. There was a strong rationale for these decisions, in line with Ministerial risk appetite. Coordinated advice was provided across policy clinical and delivery advice on the options available and ministerial decisions were made with the support of that advice.

77. There were some barriers to delivering on our collective aims, which I will outline below. It is important to note however that the range of partners involved in CHRAG, PRASCG and the Adult Social Care Gold group, our main engagement routes, as outlined at paragraph 71, worked together very well to address issues arising, and to find constructive solutions to mitigate risk. This was not without challenge however, given some of the underlying issues and conditions across the sector.

Social Care in Scotland

78. It is important to say a little about the adult social care sector in Scotland at this point, to provide context and to set out that there were longstanding issues in the social care sector of workforce supply; models of care; unmet need and; issues of viability and sustainability.

79. I have already referred to the statutory functions of local government and their delegation to IJBs. Scottish Social Services Council data from 2021 shows that adult social care services in Scotland are provided by a mixture of public (28%), private (42%) and third sector (30%) providers. In most cases where provision is not made by the public sector i.e. primarily local authorities, IJBs are responsible for commissioning social care support and services and local government carries out the procurement from the third or independent sector.

80. That data also indicates that there are currently around 208,360 people working in social care, including adult, children's and justice services. 144,380 people work in Adult Social Care and there are around 1,200 social care providers. There has been

a longstanding challenge with recruitment and retention in the sector, with a turnover of roughly 25-29% per annum. [DMB/010 - INQ000222890].

81. Further detail on Integration Joint Boards and their relationship to local Government and the NHS is usefully explained by the diagram at Annex A and [DMB/011 - INQ000222891] taken from Audit Scotland's publication on IJB finances for 2020/21 Integration Joint Boards: Financial analysis 2020/21 Financial analysis 2020/21. There is one anomaly to this structure in that NHS Highland and Highland Council operate a "Lead Agency" model. This means that NHS Highland lead on all matters relating to Adult Social Care within their territorial boundaries, although the local authority maintain statutory responsibility.

82. While overall social care stakeholders worked closely together to ensure that the appropriate guidance and support was available there were a number of lessons learned from this experience:

Lack of coherent information and data on social care provision at a national level.

83. Given that SG has no statutory function for the provision of social care support, access to coherent, national (and local) data is an area for further reflection. In pre-pandemic times there was no real locus for SG to engage with social care providers on a national basis. Each IJB or local authority holds their own information and data about social care provision for commissioning and contractual purposes. The Care Inspectorate holds information on all registered services for regulatory and inspection purposes. SSSC holds information on all registered social work and social care staff for the purposes of professional registration. All of these organisations have a specific purpose for gathering that information, and their data gathering was fit for that stated purpose.

84. The data and intelligence gathered by SG at a national level was, given the legal locus, quite rightly very minimal. This was a particular issue when trying to assess the national social care Covid position and understand where the most pressure was being exerted. The data gathered on other matters such as workforce information, fragility of provision and so on, was not gathered on a real time basis, so it was often

difficult to understand the immediate risks and issues at national and in some cases, local level.

85. The lack of rapid national communication routes with the sector also made it difficult to engage directly with social care providers or registered social workers or social care workers en-masse on guidance or other communications and this on occasion led to some fragmentation.

Variability of governance and escalation routes

86. As set out at paragraph 80 and in Annex A, the governance arrangements for social care delivery, and therefore escalation routes, are variable across the country. Local authorities hold the statutory responsibilities for social care and social work, however in many cases IJBs have commissioning and delivery oversight delegated to them. This created some complexity with communication and delivering on actions required. It is important to note that, despite this, IJB Chief Officers were a crucial part of the response and regardless of the pre-pandemic arrangements, stepped up to respond to the demands placed upon them. This, however, is an area for further reflection.

Readiness of the sector to respond

87. I was not involved with this sector until June 2020 so cannot comment on general preparedness and readiness in advance of the pandemic. However there are some important reflections that should be considered for the future:

88. **Support for care homes and the wider social care sector** – The large number of social care providers and employers across the public, private and third sectors, by its nature, means that the sector is somewhat fragmented. All providers are required to comply with regulatory and statutory functions and employment law. The Care Inspectorate regulates and inspects registered social care providers and supports a national improvement function. SSSC secure professional registration for social care workers and supports learning and development. IJBs and Local authorities commission and procure support and services. In the case of services provided by

local government, it was clear who would provide support if specific care homes or support services had resilience issues.

89. Where the third or private sector experienced such issues it was less clear who would provide additional support. This was particularly acute in instances of outbreak management in care homes. It was simply not clear at the outset where additional resilience, and in particular, staff would be secured to bolster support for services dealing with an outbreak in order to keep residents or service users safe. On occasion this required negotiation at local and, on occasion, national level to secure the necessary support where providers were unable to secure this themselves. There was some resistance to doing this on the basis that providers should have been able to manage their own issues. However this was rapidly set aside to ensure that residents and service users were kept safe. This was obviously more difficult in local areas where there were minimal in-house social care resources to draw from. On these occasions it was often the role of the NHS to step in and support struggling services. Workforce resilience and broader resilience and improvement support for the sector is therefore a critical area for reflection.

90. **Capacity within the sector**- the range of size, scale and capacity of providers across the sector is wide. Ranging from in-house local authority provision, through large private or third sector groups to individual privately owned care providers. Linking to the points at paragraphs 77-79, capacity to respond to high volume, technical and complex guidance changes, on an immediate basis, in the midst of the most challenging time in their history, tested everyone to their limits. All providers are used to complying with regulatory and health and safety requirements as a matter of course, however, some providers found this rapidly changing and often technically complex environment more difficult than others, depending on capacity and experience. This is not a reflection on staff working in the sector in any way, or on providers themselves. It was clear that everyone was doing their best in very difficult circumstances.

91. **Support for staff** – given the variable employment arrangements for staff across the sector, there were multiple contractual arrangements in place. For example, it became clear that not all staff had access to sick pay beyond the statutory minimum. This was considered risky given that we required staff to self-isolate after contact with infection,

often on multiple occasions and over long periods of time. While we had no reports of staff not complying with this, and at all times social care staff responded with huge professionalism, we were well aware that this could place significant financial pressure on a relatively low-paid workforce.

92. **Precarity of the sector** - It became clear in the early phase of the pandemic that some care homes in particular needed to sustain high levels (in some cases 95-100%) of occupancy to remain financially viable. Some of this seems to be due to the financial models applied to the running of care homes. In other cases this appears to be due to a more general tightness of margins to provide safe and high quality care. During the pandemic, given the restrictions, particularly on visiting, some people were very reluctant to be placed in a care home. This meant that some services found themselves in financially precarious positions and at risk of failure. This is a matter for wider reflection on the financial viability of, and funding models for social care services and the market more broadly.

93. It is crucial to note that SG did not wait to address the issues outlined at paragraphs 82-91. Over the course of the time period in question multiple actions were taken to address risks and issues. As outlined earlier, my role in this was not a clinical one, focusing more on policy and coherence of advice, drawing in clinical colleagues and working closely with delivery partners.

94. During the stated time period, SG and partners put in place in direct responses to the issues outlined above. Again much of this advice was not provided directly by me, but I have provided exhibits where advice or communications were submitted or circulated in my name. It is important to highlight the following in particular:

95. **Care Home oversight groups.** These local multi-agency groups, as the name suggests provided oversight of the situation in care homes and where necessary support and intervention. These worked well and provided helpful support on outbreak management, infection prevention and control, staffing support and other matters. Exhibits 12 and 13 provide further detail on the arrangements created. [DMB/012 - INQ000222892] and [DMB/013 - INQ000222893].

96. **The Safety Huddle Tool for care homes.** This system provided a national and local management information overview of the Covid status, workforce resilience and other matters for care homes. This provided daily data, provided on a voluntary basis by care homes themselves on their current status. The compliance with this voluntary reporting was excellent and it is a credit to the sector that amongst all the other challenges they faced they were able to engage with this positively. This system provided crucial data and ameliorated issues with real time data and informed support efforts on a daily and weekly basis. [DMB/014 - INQ000222894].

97. This information was regularly triangulated with data from the Care Inspectorate on staff absence, data on confirmed outbreaks with PHS and other data and intelligence collected on different timescales, using different methodology and data standards to provide a fuller picture of the ongoing situation.

98. **Sustainability funding for care homes.** This was put in place to support care home viability and to ensure that homes who found themselves financially fragile in the face of the pandemic could retain their functions and provision.

99. **Staff support fund.** This was put in place to provide support to staff who were absent from work due to Covid or because of the need to self-isolate. This was to minimize the risks outlined at paragraph 88.

100. **Death in Service payment for Social Care staff.** There was a recognition that given the range of terms and conditions across the sector many staff working in social care may not have access to death benefits. Ministers agreed that provision should be made for people given their crucial work and their inability to stay at home, unlike the advice given to the broader population. Some aspects of the funding package required legislation via regulations under the Coronavirus Act (2020). I was not involved in the initial work to set this up and whilst I led and oversaw the work on ongoing policy and delivery, implementation, continuation and changes to the regulations, again advice was submitted by team members to Ministers rather than by me.

101. **Practice Guidance.** Over the course of June 2020 to April 2022, guidance on practice changed as we moved through the different phases and waves of the pandemic. Again

this was developed in close partnership with colleagues across DGHSC, wider SG, Local Government, IJBs, providers and the wider sector.

102. In November 2020 and November 2021, winter preparedness plans were developed and published for adult social care based on the partnership model outlined above. [DMB/015 - INQ000249502] and [DMB/016 - INQ000280634].

103. As previously noted, I worked with colleagues in the provision of advice to Ministers, the writing of guidance documents, on letters to the sector and other advice and guidance. All of this guidance was signed off by Ministers after receiving advice from officials.

104. The Independent Review of Adult Social Care (IRASC) was commissioned by the Cabinet Secretary for Health and Social Care in September 2020. Some of the issues and areas of concern in social care were longstanding but many were brought into sharp focus by the pandemic. The report and recommendations from the IRASC were published on 03 February 2021 and at [DMB/017 - INQ000222895].

105. In March 2021, SG, in partnership with CoSLA, published a joint statement of intent to provide continued support the adult social care sector and to aid recovery. Progress towards delivery of this work and the updated statement of intent for 2022-23 can be found at [DMB/018 - INQ000222896].

106. The recommendations from the IRASC were accepted by the incoming Scottish Government in May 2021 and action was taken to support implementation. This included consultation on the development of a National Care Service and the legislation to support this. The summary of the consultation results, published in February 2022, can be found at [DMB/019 - INQ000222897] and the introduction of the Bill to the Scottish Parliament in June 2022, outwith the time period specified by the Inquiry. [DMB/020 - INQ000280641] [DMB/021 – **INQ000346067**

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

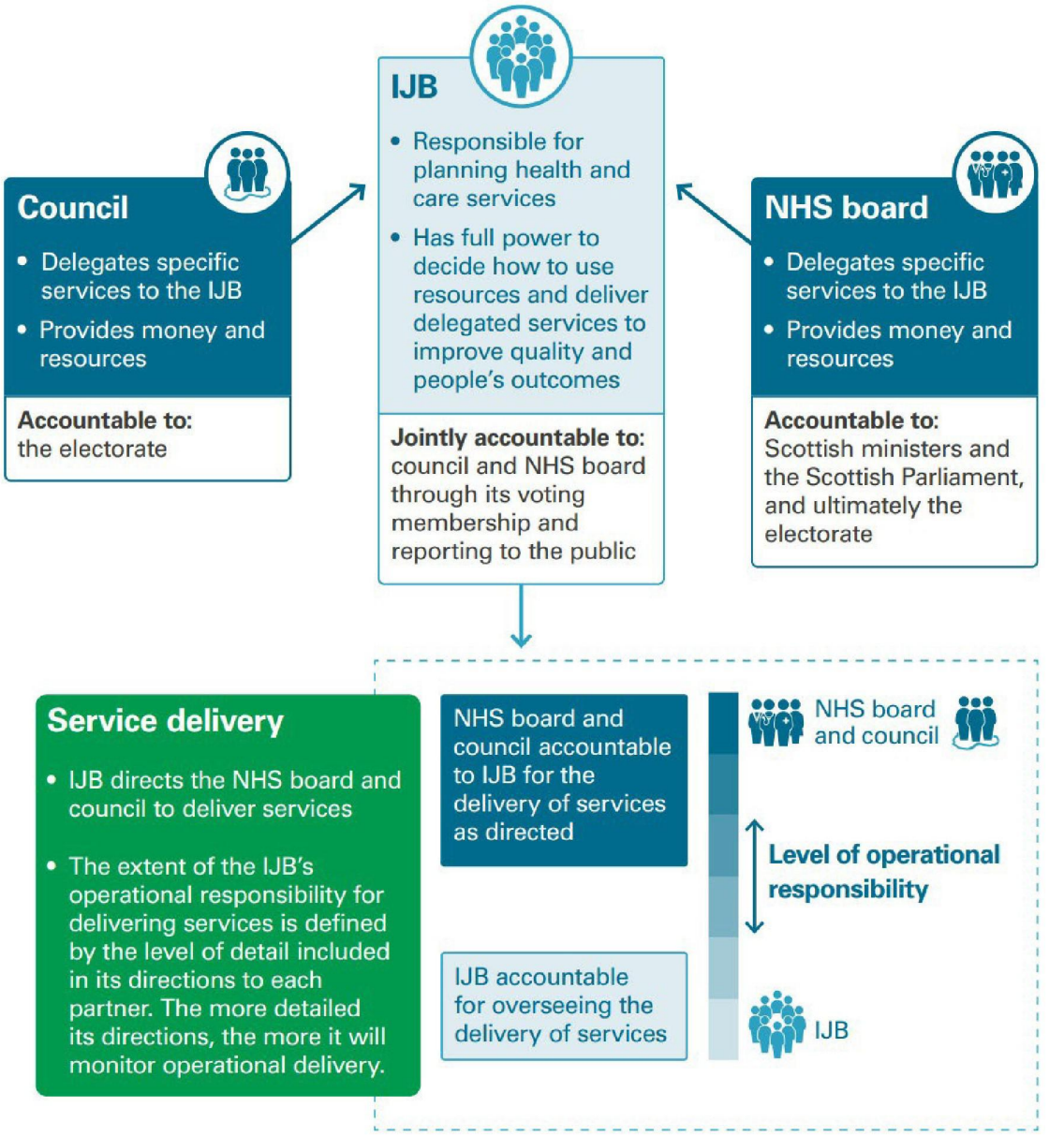
statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

PD

Dated: 13 November 2023

Annex A


IJB
• Responsible for planning health and care services
• Has full power to decide how to use resources and deliver delegated services to improve quality and people's outcomes
Jointly accountable to: council and NHS board through its voting membership and reporting to the public
Council
• Delegates specific services to the IJB
• Provides money and resources
Accountable to: the electorate
NHS board
• Delegates specific services to the IJB
• Provides money and resources
Accountable to: Scottish ministers and the Scottish Parliament, and ultimately the electorate
Service delivery
• IJB directs the NHS board and council to deliver services
• The extent of the IJB's operational responsibility for delivering services is defined by the level of detail included in its directions to each partner. The more detailed its directions, the more it will monitor operational delivery.
NHS board and council accountable to IJB for the delivery of services as directed
IJB accountable for overseeing the delivery of services
NHS board and council
Level of operational responsibility
IJB