UK Covid-19 Inquiry Before Baroness Heather Hallett

Module 3 Hearings: September to November 2024

OPENING STATEMENT

on behalf of

THE SCOTTISH GOVERNMENT

Introduction

1. In Scotland, as in all other parts of the United Kingdom, people are at the centre of the healthcare system. People are essential to the organisation, staffing and operation of the system. People depend upon the system for their well-being and survival. At no time in our recent past was this more apparent than during the Covid-19 pandemic. In all parts of the UK, there was an enormous contribution by people, for the greater good of society. The contribution made by those working in social care, in the NHS, and in the voluntary and charity sector was immeasurable, and critical to our passage though the pandemic. This was aided by the public, who either directly or indirectly, supported the provision of health and social care.
2. However, we acknowledge that the suffering was great. The loss and trauma experienced by members of the public, by healthcare and social care workers, keyworkers, and by members of the third sector was very real. On behalf of the Scottish Government, we pass on our deep sympathies and condolences to the many thousands who have lost loved ones, who have suffered and who continue to suffer because of Covid-19. Of course, throughout the pandemic the Scottish Government was steadfastly committed to taking the best possible healthcare decisions for the people of Scotland on the basis of the information that was available at the time.
3. The Scottish Government is eager to take the opportunity presented by these hearings to learn from the evidence, to identify what could have been done better and to improve government decision-making. The Scottish Government has not been complacent; it has already taken several steps in this direction, some of which we mention later in this Opening Statement.
4. In this Opening Statement, we look at certain features of the healthcare system in Scotland; together with particular aspects of the response.

Features of the Healthcare system in Scotland

5. In this section we look at certain significant features, in some instances distinctive, of the Scottish health system, and how they had a positive influence on the Scottish Government's handling of the healthcare response to the pandemic.

Relationship between the Scottish Government and NHS Health Boards

6. With healthcare being fully devolved, policy is administered through the Health and Social Care Directorates of the Scottish Government and delivered through our health boards. These structures allow for clear lines of communication and effective engagement between the Scottish Government and health boards across Scotland.

7. Prior to the pandemic, NHS Chief Executives of the health boards met regularly with senior civil servants within the Health and Social Care Directorates of the Scottish Government, and with Ministers. This meant that at the start of the pandemic there was a strong relationship and a familiar way of working already in place. This was a positive when it came to dealing with the emergency situation we all faced.

8. An example of the benefit afforded by pre-existing relationships related to capacity. The Scottish Government requested of NHS Boards that they maximise capacity, both in terms of beds and workforce. There was effective communication between the Scottish Government and the Boards, which helped to improve preparedness and readiness. The pre-existing close relationship, and subsequent effective communication, resulted in rigorous capacity planning, and thereby in the development of strong levels of mutual assurance. Consequently, effective results were seen in the following areas:
   a. The abovementioned request made of Health Boards to increase ICU capacity in hospitals led to innovation in various respects (e.g. the re-purposing of ventilators; the creation by NHS NSS of new procurement routes for equipment; and the re-deployment of staff, all of which created ICU capacity within a short space of time).
   b. The tremendous effort to establish the NHS Louisa Jordan, at pace, was illustrative of capacity planning and joint working between the Scottish Government and NHS Boards.
   c. Infection Prevention Control measures and guidance required to change frequently, to reflect the increased knowledge of how a novel virus transmitted, thereby creating safe environments for patients and staff.
   d. The repurposing of hospital provision to cope with a projected demand as a result of a complex and rapidly changing pandemic was challenging. Balancing patient care and ensuring it was delivered safely was a key achievement that healthcare workers should be proud of.

An integrated health and social care system

9. Whilst social care will be covered in detail during Module 6 of the Inquiry, it is important to note the ways in which the health and social care systems in Scotland are integrated. Decisions relating to the NHS have implications for social care and vice versa. Functions and budgets for primary and community health care, unscheduled hospital care and adult social care are delegated to Integration Authorities from health boards and local authorities. Acute/emergency care cannot operate effectively without commensurate community health care provision, social care at home and care in residential settings. For example, during the pandemic, a decision to increase hospital bed capacity had a consequent impact on capacity within the social care sector. In short, decision-making had to consider the whole system. This was achieved in large part through Scotland's integrated Health and Social Care model. Under integration, senior local accountable officer posts – Integrated Joint Board Chief Officers and Chief Financial Officers – were created. To help address issues of concern, a pattern of regular and frequent meetings with these senior local officers (whose responsibilities span both health and social care functions) was developed.

10. An example of the integrated system in operation is the rapid and effective rollout of 'Near Me'. This was an existing video consulting platform which, in March 2020, was 'scaled up' swiftly, so as to allow people to attend appointments with a healthcare professional remotely, and to allow clinical teams to maintain necessary levels of care within communities. Another example was the Nurse Director role, which worked closely with other NHS and Local Authority professional leads such as Chief Social Work Officers, IJB Chief Officers, Directors of Public Health and medical directors, to provide additional support for care home providers, including assurance and support for infection prevention and control implementation.

Absence of an NHS Trust structure in Scotland

11. The National Health Service Reform (Scotland) Act 2004 ('2004 Act') removed the Trust structure in Scotland When Scotland moved away from the Trust model. a significantly different governance and accountability structure was implemented, intended to improve

service organisation and delivery throughout NHS Scotland. The NHS in Scotland is neither designed nor structured to create competition between Health Boards. Rather, it is intended to be a cohesive system that encourages and promotes collaboration and learning between NHS Boards. This is emphasised by the duty of cooperation that the 2004 Act inserted into the National Health Service (Scotland) Act 1978 ('1978 Act').

12. There is a direct relationship in Scotland between the Health Secretary and the Health Boards that make up NHS Scotland. That relationship is underpinned by the 1978 Act. This provides powers of direction and emergency powers that enable Ministers to provide leadership to the NHS when serious issues arise. We turn to this next.

Emergency Footing

13. As mentioned, as a result of the unique way in which it is structured, the NHS in Scotland was well equipped to operate as a single system in the event of an emergency. The NHS in Scotland was initially placed on an emergency footing on 17 March 2020. By announcing the emergency, the Cabinet Secretary reminded NHS Boards of the direction making and emergency powers that allowed Scottish Ministers to secure the effective continuance of services through the on-going challenge of the Covid-19 pandemic, provided under Sections 1 and 78 of the National Health Service (Scotland) 1978 Act. The goal was to secure greater cohesion of response across Scotland, along with greater accountability. As the nation was facing a national emergency, it was necessary to ensure that every aspect of the NHS in Scotland was 'facing in the same direction'. The scale of the emergency, along with the fast developing situation, meant that both strategic and operational leadership was required in order to determine which areas should be focussed on.
14. A number of decisions were thereafter taken to ensure that the health service in Scotland was ready to deal with the modelled high numbers of people expected to require hospital treatment. This included the cancelling of elective and non-urgent healthcare; the pause on cancer screening programmes; the redeployment of staff to areas anticipating high demand from patients with Covid-19; arrangements to bring back retired health staff; and bringing into the health service final year medical students and nursing students to supplement the workforce. In addition, arrangements were put in place to work closely with our academic institutions to support education and training outcomes.

Organisation of the Directorates

15. In contrast to government departments in other parts of the UK, Scottish Government Directorates and Divisions do not operate independently of one another. Rather they constantly communicate and work together in pursuit of common goals. This was particularly so during the pandemic, when officials worked across different policy areas, and moved into new policy areas, to ensure the most effective response. For example, in March 2020 a new directorate was created in DG Health and Social Care, which from June 2020 was known as the Covid Public Health Directorate. It comprised both officials with public health expertise, and officials from across the Scottish Government, from other Directorates, who brought a diverse range of experience and skill to bear.

The Structures within which Healthcare decisions were taken

16. In this section we examine the processes and frameworks that assisted in the making of health care decisions. It is important to note that, from the outset of the pandemic, the Scottish Government put in place policies, processes, and operational frameworks to support the response. At all points it had decision making processes and structures that sought to be both reasonable and rational.

The Four Harms

17. The Four Harms approach was introduced early in the first phase of the pandemic and formed a key part of the context within which strategic healthcare decisions were made by the Scottish Government. The Scottish Government's strategic approach started with the Framework for Decision Making, first published in April 2020, and the Four Harms formed an integral part of this. It is worth noting that whilst the Four Harms helped set the tone for strategic decision making, the Scottish Government was clear from the outset that clinicians would be given the autonomy to exercise their own judgment when appropriate.
18. The Four Harms Framework identified the four main categories of harm caused by Covid-19, namely: i) the direct health impacts of Covid-19, ii) non-Covid-19 health harms, iii) societal impacts and iv) economic impacts. One notable feature of the approach taken by the Scottish Government to decision-making during the early part of the pandemic was that it prioritised the direct risk of Covid-19 to health in Scotland, over other important policy areas and considerations. This approach was refined after the introduction of the Four Harms approach, a feature of which was that it was able to adapt to the dynamic context of the pandemic, particularly throughout 2020/21, and remain aligned to the evolving strategic aims of the Scottish Government. As such, managing the risk of direct health impacts of Covid-19 remained a key focus for the Scottish Government when making decisions throughout the pandemic.
19. The Four Harms reflected the Scottish Government's understanding of the importance of the wider harms caused by Covid-19. It also understood that the harms were interlinked, and that equality considerations cut across all four areas. It understood that no decision was 'good', or risk free. It, however, allowed a conscious weighing and balancing of risks, informed by increasing knowledge and experience of how to respond to the virus.
20. The role of expert advice was key to this approach. The Scottish Government proactively opened itself to critique. A diverse range of advice was sought and considered. No one voice was dominant. This was not confined to medical or scientific advice. For example, the role of behavioural science, and the work in this regard of the Public Engagement Expert Advisory Group and the Scottish Government Covid-19 Compliance Advisory Group were key to informing the compliance chapter of the Strategic Framework, which set out the Scottish Government's strategic approach to suppressing the virus to the lowest possible level.

Four Harms covered all types of decisions

21. The approach to decision-making by the Scottish Government spanned policy, strategic, operational and grassroots decisions. This ensured that there were tangible, practical outcomes for people and communities. For example, the approach to testing and vaccine roll-out involved decisions at all levels, and was informed by equalities considerations, as seen in the work done in Glasgow mosques to encourage vaccine and testing take up within ethnic minority communities.

Four Harms and Equalities

22. The importance of equalities' analysis to the Scottish Government's decision-making is evident from the early stages of the pandemic response with a 'golden thread' that runs from that point in time to today. For example, the work of the 'Expert Reference Group for COVID-19 and Ethnicity' has left a legacy that exists some three to four years after its inception. This legacy includes leadership on anti-racism, with a senior Scottish Government Steering Group driving action to improve healthcare access, experience and outcomes, and a specific requirement for NHS Boards to develop and deliver against anti-racism plans, covering workforce and service

delivery. It also includes improvements in the collection of ethnicity in healthcare datasets (such as the mandatory collection of ethnicity in the Scottish Morbidity Records (key hospital activity datasets)), so as to gain further insights into healthcare issues and outcomes for minority ethnic groups. While, due to the pace of events in the first phase of the pandemic, Equality Impact Assessments in relation to certain decisions may not have been completed, equalities' considerations were nevertheless at the forefront of decisions. This is evident in decisions that are clearly informed by an understanding of the differential impact of the virus on certain parts of the population. For example, it is visible in the policy and strategy behind the Shielding List (and its successor, the Highest Risk List), and its evolution over time.

Aspects of the Response in Scotland

23. In this section, we examine particular aspects of the pandemic relevant to Module 3, and how the Scottish Government responded.

ICU Capacity

24. The Covid-19 pandemic had significant and wide-ranging impacts across the health and social care system. It significantly affected the flow of patients throughout the acute sector, including the ability to discharge patients from hospital. A major focus early in the pandemic was on expanding ICU capacity (including staff, space, systems, and equipment), both within the existing health estate and beyond. This included repurposing operating theatres, and later taking over other general wards to drive up critical care space, alongside efforts to expand the workforce and equipment.
25. On 17 March 2020, the Scottish Parliament was advised that while progress to double intensive care unit capacity was well advanced, the target was to quadruple the number of ICU beds. In April 2020, the First Minister advised Parliament that the initial target of doubling intensive care capacity in Scotland to 360 beds had been achieved, with the expectation that approximately 250 of these would be available exclusively for Covid-19 patients, while the others would be used for other urgent care. She then advised that work was underway to quadruple intensive care capacity to more than 700 beds for Covid-19 patients. Prior to the pandemic, double capacity was standard escalation policy in terms of influenza pandemic planning, with any further expansion being implemented only *in extremis*.
26. While there was no period during the pandemic in Scotland in which there was insufficient critical care capacity, there were times when there were serious concerns about that capacity. For example, there was pressure on the critical care capacity when combined with 'normal' winter pressures.
27. On 1 April 2020, a doubling of ICU bed capacity was achieved. In April 2021, a short life working group was commissioned to consider ICU baseline capacity, uplift capacity, and associated factors in preparation for winter 2021-2022. In light of the group's advice, the Cabinet Secretary for Health took the decision to implement an additional 30 'level 3' intensive care beds (for patients requiring highest levels of clinical support) across Scotland on a permanent basis.

Prioritisation of care

28. Decisions in this area were among the most difficult, as there was an acute awareness that the effect would be that patients outside prioritised areas would wait for treatment, in circumstances where their condition may deteriorate. The key focus was on emergency care, critical care, cancer care, maternity, and mental health.

29. The Scottish Government established a 'Clinical Prioritisation Framework', that set out six key principles that health boards followed when making decisions on elective care waiting lists. Patients were categorised into four levels of clinically agreed urgency, based on their particular clinical condition. This allowed health boards to prioritise those most in need. As with all of the decisions made by the Scottish Government, consideration of the prioritisation of care was underpinned by the Four Harms, as the key guiding framework.

Infection Prevention and Control

30. The Scottish Government played a central role in ensuring that appropriate Infection Prevention and Control (IPC) measures were in place in healthcare settings throughout Scotland during the pandemic. While the UK Government and subsequently Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) Scotland held and maintained IPC guidance for Scotland, the Scottish Government played a role in communicating updates and changes in IPC guidance to NHS Boards and other stakeholders, including unions, while working with NHS Boards to manage and reduce the number of hospital onset cases of Covid-19 through the implementation of robust IPC measures.
31. This included measures such as the appropriate use of PPE, the extended use of face masks and face coverings, physical / social distancing, ensuring optimal ventilation, enhanced cleaning measures in high-risk pathways, systematic outbreak management, healthcare worker testing and patient admission testing to ensure patients were placed in the appropriate pathway.
32. Any change to IPC measures or Covid-19 guidance was, and is, based on the latest and emerging evidence. This evidence continues to be reviewed. The Covid-19 Nosocomial Review Group (CNRG) was an advisory group set up by the Scottish Government in May 2020 to better understand healthcare-associated Covid-19 epidemiology and emerging evidence. This was in order to identify any additional IPC measures which could be considered for implementation in health and social care settings to reduce the risk of hospital associated Covid-19 infection in Scotland.
33. Although the focus of this group was on nosocomial infection and transmission, it maintained close engagement with colleagues in the Scottish Government, ARHAI Scotland and Public Health Scotland to ensure findings were shared and that policy recommendations were developed collaboratively, with system considerations.

Delayed discharge

34. Reducing the rates of delayed transfers from hospitals to the community for patients assessed as clinically fit for discharge has, for many years, been a priority across health and social care. Early in the pandemic, it was recognised that people who had already been assessed as ready for discharge should be discharged safely and quickly, both for their own wellbeing, and to maximise hospital capacity for people who were likely to require inpatient care due to Covid-19 infection.
35. Each individual decision as to whether, and when, a patient was ready for discharge was a clinical one, made by the clinician in charge of that patient's treatment, and typically once the patient has met particular clinical criteria agreed in advance by their consultant. This remained the case throughout the pandemic.

NHS Louisa Jordan

36. The decision to create one temporary hospital, the NHS Louisa Jordan situated at the Scottish Exhibition Centre (SEC) in Glasgow, was taken as a contingency measure, to ensure adequate hospital provision for Covid-19 patients, should NHS Scotland's existing estate be

fully utilised. The Scottish Government judged that what was required in Scotland was a medical treatment facility for non-critical care patients (that is, with limited ITU capacity) with a typical length of stay of up to eight days. The First Minister announced the commissioning of the Louisa Jordan on 30 March 2020. The hospital was operationally ready from 19 April 2020, and officially opened on 30 April 2020

37. The hospital had an initial capacity of 300 beds, with physical capacity to increase up to 1,000 patients, including a high-dependency area with up to 90 beds. It was used initially to support the delivery of outpatient orthopaedic and plastic surgery consultations. Some 315 patients had been seen by 27 July 2020. Subsequently, the Louisa Jordan expanded its activity, and by 7 January 2021 had seen some 18,000 patients across 14 specialties. The hospital then became a mass vaccination facility.
38. More than 32,000 outpatient and diagnostic appointments were carried out, including orthopaedics, diagnostic imaging such as CT scanning and general x-ray, dermatology, oral medicine, plastics, rheumatology, breast clinics and occupational health services. Over 6,900 healthcare staff and students were trained, and approximately 175,000 people across Greater Glasgow and Clyde area were vaccinated at the hospital. The site also supported the Scottish Blood Transfusion Service, with over 500 donations carried out, as well as providing Occupational Health Services for the University of Glasgow for nearly 1000 people. While the Louisa Jordan was not ultimately used to treat covid 19 patients, the additional capacity created was nonetheless utilised efficiently.

Use of Private Hospitals

39. There have been long-standing arrangements for NHS Scotland to utilise private sector capacity to treat NHS patients through insourcing and outsourcing. This has been done in a structured and prioritised manner to provide capacity to manage local health services where there are gaps in services or to ensure treatment is provided to avoid delays. There are five private hospitals across Scotland, with differing capabilities, offering varying services, providing a total of 213 beds, 16 theatres, and with a nursing headcount of just over 300. Utilising these hospitals therefore increased the capacity of the overall healthcare system in Scotland to provide urgent care.
40. On 20 March 2020 there was a decision to utilise private hospital capacity for the treatment of urgent elective procedures and urgent cancer cases, as hospital capacity was limited and overrun with Covid-19 admissions. This represented a positive outcome for the NHS, as it facilitated the treatment of cancer patients, and for the private sector, who otherwise would have been required to 'mothball' their facilities and place their staff on furlough. It was therefore considered to represent efficient use of resources.

NHS 24

41. As a result of the pandemic, there was a requirement for NHS 24 to completely transform their service delivery model, so as to cope with the additional pressures and demands that were placed on the service. NHS 24 has transformed from what was largely an out-of-hours service, into a 24/7 means of access to urgent care, dental advice, a dedicated Mental Health Hub and a national Covid pathway. In addition to this, the service also now plays a key role in the re-design of unscheduled care. Patients are now asked to use NHS 24 as the first point of contact, if they feel they need to access A&E, but their condition is not an immediate emergency. This has resulted in a significant increase in demand, which has in turn required a significant investment in estates, workforce, and infrastructure.

DNACPR

42. Concerns were expressed, both in the media and in the Scottish Parliament, as to whether there was a policy that permitted the blanket use of DNACPR forms. Ministers made it clear in their public and parliamentary statements that they expected everyone supported by health and social care services to be treated with sensitivity, dignity, and respect at all times, including during conversations around anticipatory care planning (ACP). They emphasised that no one should ever feel pressured to agree to a specific care plan, or to complete a DNACPR form if not comfortable doing so. In fact, it is not the case that ICU access was being restricted in any way by the Scottish Government. No instruction or guidance was issued to GPs, or to anyone else, that indicated any such restriction. Specifically, the Cabinet Secretary for Health and Sport, Ms Freeman, announced an intention to quadruple ICU bed capacity in order that the NHS Scotland was prepared for even the reasonable worst-case scenario.

NHS NSS / PPE

43. The importance of ensuring that appropriate PPE was available to healthcare workers was a key concern for the Scottish Government throughout the pandemic.
44. A significant feature of the distinctive health infrastructure in Scotland, and one which made a significant contribution to the pandemic response, is National Services Scotland ("NHS NSS"). A unique Health Board, NHS NSS acts as a procurement arm for the entire NHS in Scotland in relation to a wide range of medical supplies and equipment. NHS NSS has 'tried and tested' procedures in place that apply to 'due diligence' in relation to suppliers, the pricing of goods, quality control, distribution and supply. NHS NSS has longstanding, trusted relationships with a diverse range of suppliers.
45. The Scottish Government tasked NHS NSS with overseeing the procurement and delivery of PPE before, during and throughout the pandemic. This issue will be considered further during Module 5 of this Inquiry but is a helpful illustration of the close and effective working between the Scottish Government and Health Boards throughout the pandemic.
46. Because it was able to track both the source and destination of all items of PPE in Scotland, NHS NSS was also critical in managing the PPE stock. The Cabinet Secretary received a daily report on levels of PPE held both 'in stock' and 'on order', and could therefore personally investigate any areas of concern, and address the same. The information provided by NHS NSS to her covered each item of PPE, current volume, current order volume and new deliveries expected. All primary and social care settings could be supplied with PPE from bespoke ordering and distribution routes.
47. PPE was distributed on behalf of the Scottish Government by NHS NSS. Pandemic stockpile PPE holdings were released to NHS NSS, who provided this PPE to Health Boards and Primary Care ICs. These stocks were augmented by procurement of further pandemic PPE, principally carried out by NHS NSS using funds provided by the Scottish Government for that purpose.
48. On 26 May 2020, the CNO sent a letter to NHS Board Chief Executives providing clarity on the Scottish Government's policy regarding the reuse of single-use PPE. The Scottish Government was clear that single-use PPE must not be reused and should be disposed of after use into the correct waste stream.

Maternity care

49. Between March and May 2020, changes were made to maternity services in health boards, including suspension of home birth services, withdrawal of some services (such as hypnobirthing classes and waterbirths), closure of community midwifery units, and suspension of face-to-face antenatal care.

50. On 8 April 2020, the Scottish Government issued guidance outlining that maternity services should maintain a minimum of six antenatal visits. Health Boards did not report that they were unable to achieve the minimum contacts required.
51. In light of the advice to pause group antenatal care, the SG procured an online antenatal course, the 'Solihull Online Antenatal Course', and made it freely available to all pregnant women in Scotland, via advertising on NHS Inform and the parentclub.scot website.
52. From the summer of 2020, the Chief Midwife Officer outlined the expectation that services should return as quickly as possible. She followed up directly with Boards that were slower at reinstating these services. Informed by discussions with Heads of Midwifery and Obstetric Clinical Directors, the Scottish Government issued a range of guidance to maternity services in Scotland. This was updated as the pandemic proceeded. It set out minimum agreed standards for planned maternity care during Covid-19.
53. In response to concerns from clinical teams, the Scottish Government procured the use of the *'vCreate'* system in all neonatal units in Scotland. *vCreate* is a secure video messaging service, which allows clinical staff to communicate with parents via video link, in order to assess premature newborns' development. Clinical teams were concerned about follow-up by neurodevelopmental teams in their assessments of premature infants via virtual clinics. *vCreate* was already being used in this way in other parts of the NHS, and neonatal clinicians presented a business case seeking to extend the use into neonatal neurodevelopmental follow-up.

Use of Technology

54. The use of digital technologies was critical in the Scottish Government's response to the pandemic. The rapid 'scale up' of NHS Near Me is an example of the type of support that was made available through the use of technology. NHS 'Near Me' (Scotland's public-facing name for the Attend Anywhere platform) was an existing video consulting platform which was rapidly rolled out for use once social distancing and restricted travel came into effect. Prior to the pandemic, NHS Near Me was already in use across 11 of the 14 territorial Health Boards, along with a range of third sector organisations. Approximately 1,000 video calls per month were undertaken in early 2020.
55. The rapid scale-up of a 2018 commitment to upgrade and roll out Microsoft Office 365 and Teams applications took place across NHS Scotland, as an immediate priority to support business continuity challenges during Covid-19.
56. An example of the people-centred approach was the launch of the 'Protect Scotland' app, which was designed to support proximity alerts, and to share the 'Protect Scotland' Equalities Impact Assessment (EQIA). This clearly addressed the accessibility of the new technology introduced by the Scottish Government during the Covid-19 response in relation to protected characteristics. A Children's Impact Assessment for Protect Scotland was carried out to assess any potential impact for children and young adults.
57. Prior to the Covid-19 pandemic, Scottish Government Digital Health and Care had established an Equalities Board to be a lead stakeholder group. It offered advice and direction on new technology and systems.
58. The Scottish Government commissioned the National Vaccination Helpline, operated by the National Contact Centre at NSS.
59. The Scottish Government also commissioned the national online vaccination booking portal, to allow people to book online, offering a choice of location, date, and time of appointment.
60. As noted above, the Scottish Government procured the use of the 'vCreate' system in all neonatal units in Scotland and an online antenatal course, the Solihull Online Antenatal Course, and made it freely available to all pregnant women in Scotland.

Impact on Doctors, Nurses and Healthcare Staff

61. Responding to the unique challenges presented by the pandemic took a significant, and understandable, toll upon the health and social care workforce in Scotland, and across the UK. Understanding this toll was particularly important in order to ensure wellbeing, and to identify opportunities to improve conditions where possible.

62. The number of staff working in NHS Scotland on 31 March 2020 was 167,022. By 31 March 2021 this had increased to 177,706. By 31 March 2022 it increased to 181,723 (although by 30 June 2022 it had dropped slightly to 179,849). Between 13 April 2020 to 20 July 2022, the Scottish Government was notified of 27 deaths of NHS Scotland staff by the health boards caused by or suspected to be related to Covid-19.
63. At the start of the pandemic, the Scottish Government established the Workforce Senior Leadership Group (WSLG), which brought together senior representation from government, health and social care employers, trade unions and representative bodies. This partnership group first met on 23 March 2020, to discuss and provide strategic guidance and advice. The group continued to meet as frequently as appropriate, sometimes daily through the phases of the pandemic, reflecting the nature of advice and engagement that was required. Members engaged in open and honest discussions to support decision making, focusing on strong, positive, and constructive relationships which helped support the workforce to adapt to the challenges presented throughout the pandemic.
64. The WSLG built upon the Scottish Government's longstanding partnership working arrangements with key stakeholders represented within the group, as well as regular meetings between Ministers and Trade Unions. These partnerships rely upon openness, honesty, and a commitment to share information in a transparent manner. This allowed us, where necessary, to temporarily adapt terms and conditions and, where appropriate, policy approach based on real time feedback from staff representatives to help better support NHS staff and NHS services. This included consideration of work programmes and working locations to ensure the best placement and use of resources during this time.
65. On 14 May 2020, Scottish Ministers established a special temporary scheme. It provided a lump sum and survivor's benefits upon the death in service of those working for, or providing services on behalf of, an NHS Scotland health board, a special health board, NHS NSS, or Healthcare Improvement Scotland. It applied to those who did not otherwise have equivalent life assurance cover provided through NHS Pension Scheme membership. In total, 19 claims were paid out from a total of 21 applications to the scheme, with the total payout to claimants and families being £1.438 million.
66. A National Wellbeing Hub for healthcare staff was launched on 11 May 2020. This was an interactive website that provided a range of resources to help the Health and Social Care Workforce as they responded to the Covid-19 pandemic. It was developed to meet the identified need for a single point of access to wellbeing support for the workforce.
67. On 1 May 2020, the Minister for Mental Health agreed to the establishment of a National Helpline for the Health & Social Care Workforce. This helpline, dedicated to helping members of the health and social care workforce, was based within NHS 24's Mental Health Hub and launched on 20 July 2020. The unique service gave staff access to psychological first aid and a compassionate listening service whenever they feel they need it – 24 hours a day, 7 days a week.
68. On 10 August 2020, the Cabinet Secretary agreed to provide a suite of services to support the wellbeing and mental healthcare needs of the Health and Social Care workforce during and beyond Covid-19. The suite of services to support the wellbeing of staff included: continuation

of funding for the National Helpline; coaching for wellbeing with the addition of up to 100 new places / 200 hours per month through 2021-22; digital resources; formal psychological interventions & the Workforce Specialist care service that focuses on those who due to their professional role, have difficulty accessing confidential assessment and treatment for mental health.

69. On 30 November 2020, the First Minister for Scotland announced a £500 one-off payment for all health and care staff as a thank you for helping Scotland cope with Covid-19. The Scottish Government, employers and staff side worked in partnership through the Scottish Terms and Conditions Committee to agree the fairest way of allocating this payment to NHS Scotland staff. The one-off pro-rata non-consolidated £500 was payable to all directly employed NHS staff, as well as staff bank workers and locums paid through NHS Payrolls who had at least one month's continuous service in the NHS Scotland between 17 March and 30 November 2020.
70. On 26 February 2021, a Workforce Specialist Service was launched. This service offered confidential mental health assessment and treatment for regulated health, social care, and social work professionals in Scotland.
71. As a result of the WHO additional recommendation on the use of FFP2/FFP3 masks by health and care workers in light of the increased transmission of Omicron variant, the Scottish Government wrote to Health Boards on 19 April 2022 advising that an individual risk assessment could be carried out by line managers in line with current guidance, taking into consideration staff members' overall health, safety, physical and psychological wellbeing, as well as any personal views/concerns about risks. This was in addition to the process and risk assessments already in place for the use of FFP3 masks for health and social care staff when performing an aerosol generating procedure.

Long Covid

72. A consistent concern raised by Long Covid sufferers is that they have struggled to have their 'voices heard', have faced difficulties in obtaining a diagnosis and suffer feelings of isolation and abandonment by the medical profession. We wish to reassure the Inquiry and Long Covid sufferers that the Scottish Government is committed to ensuring that every person with Long Covid is supported with access to the care they need, in a setting that is as close to their home as possible.
73. We would highlight the publication by the Scottish Government in September 2021 of "*Scotland's Long Covid Service*". The document sets out the Scottish Government's approach and commitment to supporting the health and wellbeing of Long Covid sufferers. The approach is based on maximising and improving co-ordination of the broad range of existing services across Scotland's health and social care system and, in the third sector, those that are relevant to the range of symptoms experienced by Long Covid sufferers. The Scottish Government's approach is based on four key elements:
    - Supported self-management
    - Primary care and community-based support
    - Rehabilitation support
    - Secondary care investigation and support
74. The aim is to make sure that Long Covid sufferers receive a person-centred response targeted to their individual needs.
75. The measures set out in *Scotland's Long Covid Service* have been supported by the establishment of a £10 million Long Covid Support Fund, which aims to support NHS Boards to increase the capacity of existing services that provide support to people with Long Covid, to develop these into more clearly defined pathways, and to provide a more co-ordinated

experience for those accessing support. NHS Health Boards are responsible for delivering services to meet the needs of people suffering from Long Covid in their areas. The Long Covid Support Fund is designed to be a flexible fund that can be matched to local needs. It will strengthen the range of information and advice available, and ensure the right support is available within primary care, providing a response focused on each patient's needs, with referrals to secondary care where necessary. A total of £6 million has been made available from the Long Covid Support Fund over 2022-23 and 2023-24, and a further £3 million is being made available in the current financial year. In addition, NHS National Services Scotland has established a national strategic network for Long Covid. This brings together representatives from NHS Boards across Scotland to provide a forum for the exchange of learning and best practice, from within and beyond Scotland, in developing support and services for people with Long Covid.

Shielding

76. The shielding programme aimed to reduce the risk of infection, severe illness, and death. The four UK CMOs, working with other senior clinicians, jointly identified certain health conditions that empirically were likely to present a higher risk of negative outcomes for certain people, if they contracted Covid-19. It was the clear and stated policy intent from that point onwards to identify, protect and support people considered to be at highest risk of severe illness or death from Covid-19. The early Shielding policy, in which people were advised to self-isolate strictly, was an example of a precautionary approach, which was based on the limited evidence available at the time.

77. From the outset it was decided by the CMO that the Scottish Government would follow the same identification process and communications as the UK Government, to maintain consistency across the four nations. Using their clinical judgement, clinicians could also add people to the 'Shielding/Highest Risk' list, if they were at the highest risk from Covid-19, but were not included in Groups 1– 6 (which groups had been set by the four CMOs). A "Group 7 – clinician-identified" cohort was therefore established.

78. Shielding advice and guidance was disseminated to those on the Shielding/Highest Risk List and to the general public by DG Health and Social Care in several ways –
    - Letters from the CMO sent to the Shielding/Highest risk cohort.
    - An SMS alert service to the shielding/highest risk list (for those who signed up for it). This service was operated by NHS NES, with the content of the messages being created by the Shielding/Covid Highest Risk Division.
    - More generally, information about Shielding/Highest Risk was disseminated via regular updates to the guidance on the relevant Gov.scot pages.
79. The Scottish Government, via the Pharmacy and Medicine Division, worked with pharmacies to support the delivery of prescriptions to those who needed support, including those who were shielding, prioritising those who were not able to leave the house. It was recognised early in the pandemic that asking people to shield would impact their access to healthcare systems, specifically access to prescriptions and medicines, as well as their access to supermarkets and shops. Therefore, in the week commencing 23 March 2020, the Scottish Government began working with Regional and Local Resilience Partnerships and multiple retailers to put in place a package of support to help people self-isolating to access food and medicines that they could not get themselves.
80. The Scottish Government recognises that shielding was tough. Many shielding individuals tried to follow the guidance to the best of their ability, but practical constraints, caring duties and quality of life considerations made this at times very challenging. There are lessons to be learned around the support that is necessary to enable people to shield. But it also raises

questions around what is, and what is not, feasible in terms of 'shielding' those at the highest risk. The principle of protecting those at higher risk, however, remains valid.

81. Studies showed being on the "Highest Risk List" in the longer term made people feel more vulnerable. Confidence leaving their home, physical activity, quality of life and mental health were all negatively affected. Whilst it is difficult to take a fully individualised approach to protect people at highest risk, providing guidance at the outset which emphasises the need for people to take advice from their own GP or specialist clinician in order to protect themselves is one approach to consider rather than giving blanket advice. Essentially it is also the actions of others that we need to consider in the protection of people at higher risk and influencing – particularly if taking a truly person-centred approach.
82. For the greater part of the 'lifespan' of the List, the number of persons shielding stood at 180,000–185,000. When on 31 May 2022 the Highest Risk List came to an end, the number of individuals on the list stood at 175,193. In total, 216,710 individuals were on the Shielding/Highest Risk List.

Recent Developments

83. In this section, we look at some recent initiatives and developments connected to the pandemic.

NHS Recovery Plan

84. On 25 August 2021, the Scottish Government launched the NHS Recovery Plan, the central purpose of which was to create additional capacity within the NHS to aid the resumption of elective care. The plan reflected that the Covid-19 pandemic represented the biggest shock that the NHS had faced in its existence, and the need to build back a better NHS in Scotland in response to this.
85. The plan looked at increasing capacity and reducing waiting times over a five year period. It committed over £1 billion to help deliver necessary reforms and capacity within the health service including significant investment to reduce waiting times for elective surgery. Through the investment in National Treatment Centres the Scottish Government had the ability to create capacity for tens of thousands of additional treatments. The recovery plan also committed the Scottish Government to investing £29 million to target diagnostic backlogs, providing 78000 additional diagnostic procedures in 2021-2022, rising to 90,000 per year from 2025-2026.
86. The recovery plan also covered a wide range of key areas for healthcare delivery in Scotland, including primary and community care, cancer treatment, mental health, staffing and wellbeing on frontline healthcare workers.
87. The Scottish Government published a progress report in December 2023, noting a number of milestones that had already been reached in delivering the plan, these included:
    a. Ongoing national and international campaigns to support the recruitment of over 800 international nurses, midwives and AHPs, as well continuing to increase the number of undergraduate medical training places, with 100 places having been added in the academic year 2023-24
    b. The opening of two further National Treatment Centres in 2023 in NHS Fife and NHS Highland to support year on year reductions in waiting lists by providing additional capacity for orthopaedics and, ophthalmology.
    c. Continued progress on directly funding mental health services for children and young people.

Initiatives

88. The then Covid Public Health Directorate helped to prepare the report, '*Lessons identified from the initial health and social care response to Covid-19 in Scotland'* which covered the initial six months of the response to the pandemic and was published in August 2021.
89. The Directorate for Population Health leads on planning for, preparing for, managing Covid-19 and future pandemics, and providing advice to Ministers. To help provide that advice, the Standing Committee on Pandemic Preparedness (SCOPP) was established in August 2021.
90. A review has been carried out, commissioned by Public Health Scotland, of the Scottish Health Protection Network (SHPN), designed to ensure its form, structure and outputs remain fit for purpose. The Scottish Government contributed to this and has responded to the report. The SHPN are currently working to implement the recommendations from the review.
91. The Directorate for Population Health has prepared for future threats from Covid 19 and any variants and mutations, by developing the 'Variants and Mutations and Surveillance Plans' in partnership with PHS. Health Resilience and Protection Division work closely with Public Health Scotland (PHS) and other key stakeholders to ensure there is a comprehensive respiratory surveillance programme in place to monitor respiratory pathogens including SARS-CoV-2. Scotland's National Respiratory Surveillance Plan was first published in September 2022 and an updated plan published in July 2023.

Conclusion

92. We hope that the Inquiry will find this Opening Statement a useful insight into how certain significant features of the health and social care system in Scotland assisted the Scottish Government's response to the pandemic, as well as providing some detail as to how the Scottish Government handled specific aspects of that response.

93. We trust that we can be of assistance to the Inquiry in the weeks to come. As ever, the Scottish Government remains committed to the Inquiry, and to learning of ways in which processes, structures and decision making may be improved.

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